GEORGIA CHILD FATALITY REVIEW PANEL

(Formerly "Statewide Child Abuse Prevention Panel")

Annual Report
Calendar Year 2000

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GEORGIA CHILD FATALITY REVIEW PANEL

MISSION

To serve Georgia's children by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse cases and child fatality investigations, and monitoring the implementation and impact of the statewide child abuse prevention plan in order to prevent and reduce incidents of child abuse and fatalities in the State.

Acknowledgements

The Georgia Child Fatality Review Panel wishes to acknowledge those whose enormous commitment, dedication, and unwavering support to child fatality review have made this report possible. These include:

- Dr. John T. Carter, Ph.D. , Jill Andrews, and associates of the Epidemiology Department of Emory University, Rollins School of Public Health
- All the members of county child abuse protocol and child fatality review committees
- All the public/private agencies that have so willingly collaborated with this office and provided support

GEORGIA CHILD FATALITY REVIEW PANEL

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The Georgia Child Fatality Review Panel is an appointed body of 16 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data. Two year appointments are made by the governor except as otherwise noted.

1 Appointed by the Lieutenant Governor
2 Appointed by the Speaker of the House of Representatives
3 Ex-Officio

MESSAGE FROM THE CHAIR

The year 2000 marked a decade of the child fatality review system in the State of Georgia. We have shown promise in some areas. During the decade:

- The average number of fire-related child deaths for the past four years (18.5) is less than half the average number for the preceding seven years (41)
- The death rate among African American males due to firearms is at its lowest point

Yet, we remain challenged in others:

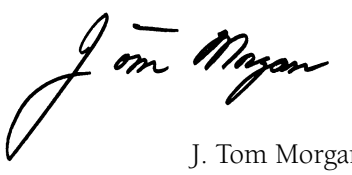
- Deaths to children less than 5 years of age make up more than 70% of all deaths related to child abuse and neglect
- Motor vehicle crashes remain the leading cause of death for 15 to 17 year olds

The question is often posed, "What can we do"? The answer to this question is very complex and multi-faceted. One promising initiative for ensuring the protection of abused and neglected children was the creation of the Office of the Child Advocate. Since it's inception, this office, under direction of DeAlvah Simms (Child Advocate), has aggressively advocated to bring about positive change for children. However, there are other simple, yet powerful proposals that would assist in our efforts to promote safe and healthy environments for our children. These include:

- Passage of a Child Endangerment Statute to ensure that parents/caretakers who knowingly create and/or allow children to be placed in dangerous situations and circumstances are held accountable
- Further expansion of Child Death Investigation Teams to ensure that death scene investigations of child deaths are conducted by trained, skilled professional teams. We must identify and hold accountable those who perpetrate crimes against children
- Appropriate additional resources for protective services workers to adequately protect children
- Appropriate resources to support child fatality review committees who act as sentinels in the protection of children
- Employ proven prevention strategies to reduce the risk of children being harmed

We are living in difficult economic times. However, our economic challenges must not be met at the expense of the children in this state. Just as those difficult times challenge you and I, how much more so children living in "at risk" situations? These are children whom we may not know personally or may never see. Yet, as children of this state and our communities, they are our children. We are responsible for the welfare of all Georgia's citizens. Children must grow up in safe, secure, and nurturing environments.

We have embarked on both a new millennium and a new decade that offers us yet another opportunity to demonstrate our commitment to the children of Georgia. Together, we can meet the challenge.



J. Tom Morgan, Chairperson
Georgia Child Fatality Review Panel

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Terrorism is intended to provoke intense fear and anxiety, using violence as a means of coercion. On September 11, 2001, our country experienced acts of terrorism to a degree never experienced before. Many Americans sat helpless as they watched their world—family, job, and sense of security—come tumbling down right before their eyes. Our nation's response to these horrific acts was a declaration of war against terrorism, and a pledge that this war would not end until terrorism is eradicated. We all joined in united efforts to ensure that the families who lost loved ones would be cared for.

Terror, however, continues as a way of life for many children living in this country, including our great state of Georgia. Everyday, children die preventable and often horrific deaths, frequently at the hands of their parents/caretakers. Is it because these children's deaths are not typically en masse or the focus of unrelenting media scrutiny that we continue to ignore them? When will we declare war on the terror of child abuse, or the societal elements that cause children to die preventable deaths everyday? Just as our nation has committed resources to end terrorism, let Georgia commit needed resources to end child suffering and death.

In year 2000, 1,761 of Georgia's children died according to Vital Records' preliminary file. The Georgia Child Fatality Review Panel (Panel) publishes an annual report which contains detailed information, compiled from reports submitted by local county child fatality review committees, regarding those deaths which are sudden, unexpected, and/or unexplained.

The Panel is charged with not only tracking the numbers and causes of child death, but also identifying and recommending prevention strategies that could reduce the number of children who are deprived of their childhood.

Key Findings

Fatal Child Abuse/Neglect

Child fatality review committees determined that 92 child deaths were suspected or confirmed abuse and/or neglect. Thirty (30) of those abuse related deaths were ruled homicides. Seventy percent (70%) of those homicides resulting from abuse involved children under the age of 5. Perpetrators were identified in 44 of the child abuse related deaths and 64% of those perpetrators were parents.

Natural

Death certificate data indicated a total of 1,306 children under the age of 18 died of natural causes (including SIDS). Infants accounted for the vast majority (1,060) of those deaths. The leading causes of infant deaths were congenital anomalies, low birth weight, and prematurity. There were 117 SIDS deaths.

Child fatality review committees reviewed 169 deaths from natural causes. Ninety-one (91) of those deaths were SIDS. Committees are required to review all SIDS deaths, and medical deaths that are unexpected or unattended by a physician.

Unintentional Injuries

Death certificate data indicated that 61% of deaths (390) in children ages 1 – 17 resulted from injuries. Seventy-seven percent (77%) of all injuries in this age group resulting in death were unintentional. Leading causes of unintentional injury related deaths included motor vehicle crashes (195), drowning (47), and suffocation (39). The most marked increase in deaths from 1999 was fire related deaths (160%), and the most marked decrease was poisoning (50%).

Child fatality review committees reviewed 235 deaths determined to have resulted from unintentional injuries.

Intentional Injuries

Death certificate data reported 106 children died from injuries intentionally inflicted by themselves or another (suicide and homicide). In 2000, there were 76 homicides and 30 suicides. Homicides among whites represented a 65% increase from the previous year due to the increase among white males (8 in 1999 to 23 in 2000). Suicides represent a 15% increase overall.

Child fatality review committees reviewed 80 deaths that were intentional – 58 homicides and 22 suicides.

Firearm Deaths

Death certificate data indicated firearms were used in 45 child deaths. Twenty-three (23) of those deaths were ruled homicides, sixteen (16) suicides, and three (3) unintentional shootings. The circumstances of 3 firearm deaths were undetermined.

Child fatality review committees reviewed 44 firearm related deaths. Ninety-one percent were intentional. The type of firearm was identified in 41 of the 44 firearm related deaths. Handguns were most frequently used (29 of the 44 reviewed firearm deaths.)

Preventability

A primary function of the child fatality review process is to identify those deaths believed to be preventable. The issue of preventability was addressed in 470 of the 484 child deaths reviewed. Child fatality review committees determined that 354 (75%) of the 470 child deaths were definitely or possibly preventable.

Agency Involvement/Intervention

Child fatality review committees reported that in 66% (61) child abuse/neglect related deaths, the child and/or family had prior involvement with at least one state or local agency. Committees identified 15 instances in which agency intervention could have prevented a number of these child abuse/neglect related deaths.

RECOMMENDATIONS OF THE GEORGIA FATALITY REVIEW PANEL

Children can be better safeguarded if the valuable information in this report is used by readers to encourage implementation of the Panel's proposed recommendations. A summary of those recommendations to the Governor, General Assembly, and the public is listed below:

Legislative Recommendations:

1. Fully implement recommendations of the Child Protective Service Task Force to improve the state's ability to protect children from child abuse and neglect
2. Fund expansion of home-based family support models that promote and enable appropriate parenting skills for prevention of child abuse and neglect
3. Require fences and gates in public and private swimming pools statewide
4. Require an autopsy, including toxicology studies, for every death of a child under the age of seven with the exception of children who are known to have died of a disease process while attended by a physician. Further, complete skeletal x-rays (following established pediatric and radiological protocol), of the bodies of children who died before their second birthday, along with immediate drug screens of people in the area of a child death, should be required
5. Pass a "Child Endangerment Law" to hold adults accountable who knowingly create or allow children to be placed in dangerous situations
6. Provide sufficient funding to the Georgia Child Fatality Review Panel and the local committees to fulfill their statutory requirements
7. Expand funding for mental health services for children, especially those identified as "at risk"

Agency Recommendations:

1. DFCS: The Panel recommends that all cases of newborns whose mothers have a positive drug screen be referred to juvenile court
2. DFCS: The Panel recommends that when a child dies due to a parent's or a caretaker's neglect or aggression, that ongoing efforts be made to visit the surviving children in that home to assess the safety and well-being of these children and enable voluntary referrals to appropriate services
3. GBI, and Medical Examiner's Office: The Panel recommends that a death scene investigation be conducted for any child death suspected of being accidental, a homicide, or of unknown causes. No case should be classified as SIDS unless a death scene investigation and investigation of the clinical circumstances are done

Recommendations for the Public:

1. Properly secure children in appropriate child passenger safety seats or seat belts at all times
2. Always supervise small children while playing in or near water (tub, pool, beach, etc.) even if they know how to swim
3. Place babies on their backs while asleep and remove all soft bedding or other soft materials
4. Place babies alone in a crib to sleep. Co-sleeping places a child at risk for suffocation. This risk is further magnified if the caretaker has been drinking or using drugs
5. Keep toxic substances out of reach of children
6. Ensure that there are a sufficient number of properly functioning smoke detectors in the home
7. Keep children away from guns and guns away from children. All guns should be stored in a locked, secured place that is inaccessible to children and ammunition be securely stored separately. Also, parents should ask if there is a gun in the home where their child will be playing

CHILD DEATHS IN GEORGIA

Each year in Georgia hundreds of children die before they reach the age of 18. The majority of these children die before their first birthdays. In 2000, 1,761 children died, which was equivalent to almost five children dying every day. Unfortunately, these deaths represent only a small percentage of serious injuries to children. Many children suffer preventable non-fatal injuries that result in disabling conditions. These non-fatal injuries impose tremendous emotional, social and economic costs for families, communities and the state. The purpose of the child fatality review process is to analyze the circumstances of child deaths. This process is critical in identifying prevention strategies that can help reduce these needless costs and improve the health and well being of Georgia's future generations.

Information Sources

Child fatality review reports are the primary source of data for this report. Child fatality review reports are submitted on deaths that are identified by the county coroner, medical examiner, or child fatality review committee. In addition to the SIDS and unintentional/intentional deaths, the committee may identify other deaths as appropriate for review. Child fatality review reports provide details of the cause and circumstance of death, supervision at time of death, prior history of abuse or neglect, perpetrator(s) in child abuse-related deaths, and prior agency involvement. Reports also contain information regarding whether a death might have been prevented and what measures might be taken to lessen the likelihood of a similar death occurring in the future.

A preliminary 2000 death certificate file was used to describe all child deaths; therefore, the numbers for infant and child deaths in Figure1 may vary slightly from the final Georgia 2000 vital statistics data. The death certificate file was also used to identify the subset of deaths that met the criteria for review. The child fatality review file was linked with the death certificate file. The death certificate provides demographic information and states the official cause of death. These two data sources do not always agree on the cause or manner of death. In 18 deaths, child fatality review committees determined the cause or manner of death for a child to be different from the reported cause or manner on the death certificate based on additional information made available to the committees.

Of the 1,761 child death certificates filed in 2000, 572 met the criteria requiring review. Child fatality review committees reviewed 381 (67%) of these eligible deaths, 16 deaths for which no death certificate was issued, 7 deaths of out-of-state residents, and additional deaths related to medical causes. A total of 484 deaths was reviewed and are included in Appendix C.2 of this report.

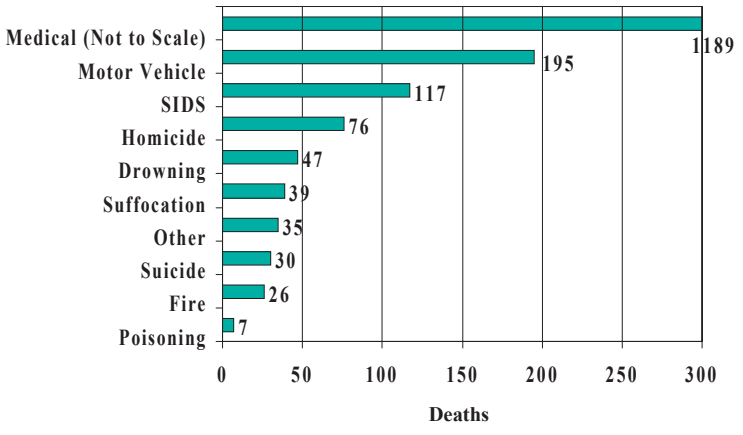
Except as noted, information and figures from child fatality review reports are designated by the term "Reviewed Deaths", and include a total of 406 child deaths (injury-related and SIDS). All information on "Trends" is based on death certificate data.

SUMMARY OF ALL DEATHS

Figure 1 shows the causes of all 1,761 child deaths in Georgia in 2000. Natural causes were responsible for 74% (1,306) of all deaths, with 81% (1060) of these deaths occurring before age one.

The term "medical" when used in this report as a cause of death for infants does not include SIDS.

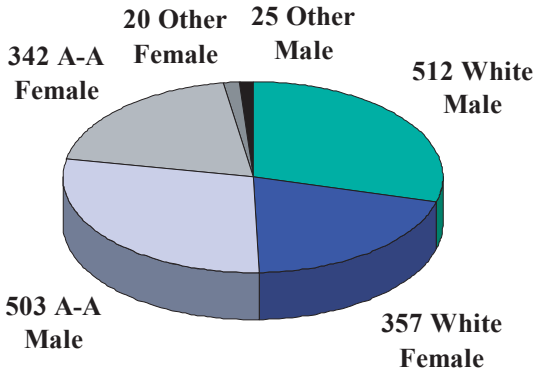
Figure 1. Deaths to Children Under 18 in Georgia
All Causes based on Death Certificate



Findings

- The total number of infant/child deaths (1,761) is higher than the totals for the preceding 3 years (an average of 1,701 for 1997 through 1999). The increase is a result of infant deaths due to medical causes (up to 943 in 2000 from an average of 872 for the preceding 3 years)
- The number of motor vehicle related deaths (195) was the lowest since 1994
- Homicide deaths increased to 76 after remaining below 70 for the past 3 years

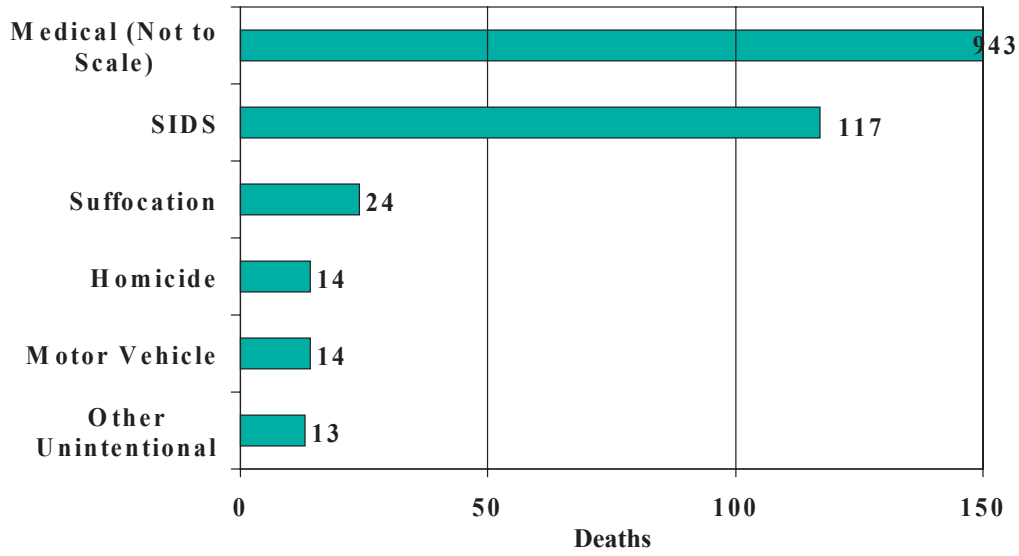
Figure 2. Race and Gender of All Child Deaths



Findings

- Though African American children make up only 34% of the child population, their deaths make up 48% of all child deaths
- Although not shown in the figure, there was an increase in deaths among all children identified as Hispanic (from 63 in 1999 to 85 in 2000)

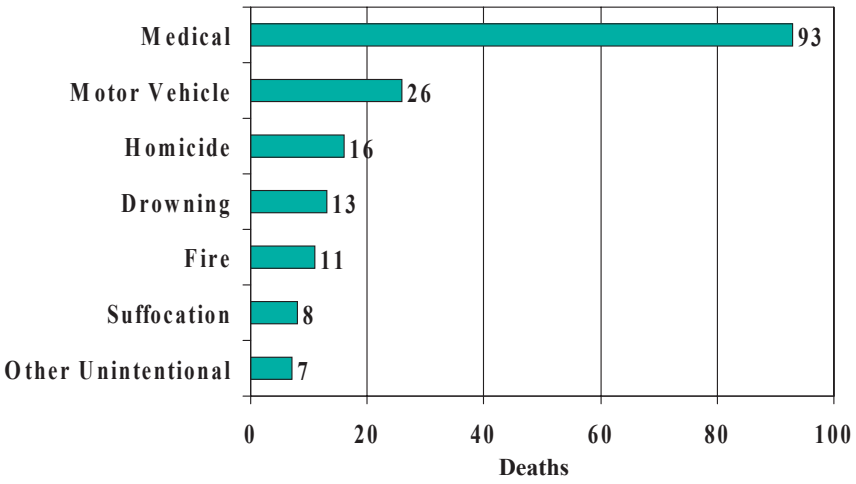
Figure 3. All Causes of Death, Age < 1



Findings

- Only 65 (6%) of infant deaths resulted from unintentional or intentional injuries. However, this is an increase from 48 in 1999
- Of defined causes, suffocation (24) was the largest single injury related category

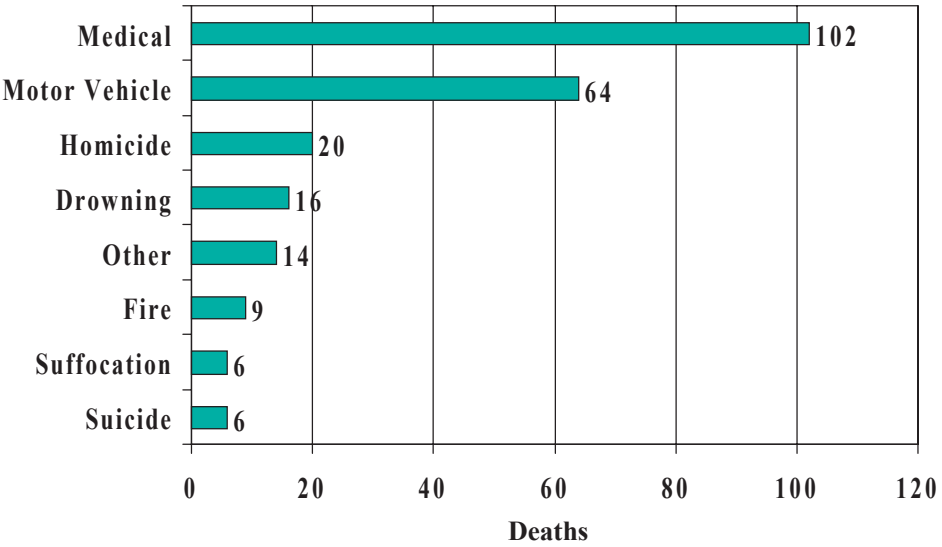
Figure 4. All Causes of Death, Age 1-4



Findings

- Deaths among this age group increased slightly in 2000 (from 161 in 1999 to 174)
- 32% of injury related deaths were a result of motor vehicle crashes
- Deaths due to fire increased to 11 after an average of 5 for the past 3 years

Figure 5. All Causes of Death, Age 5-14



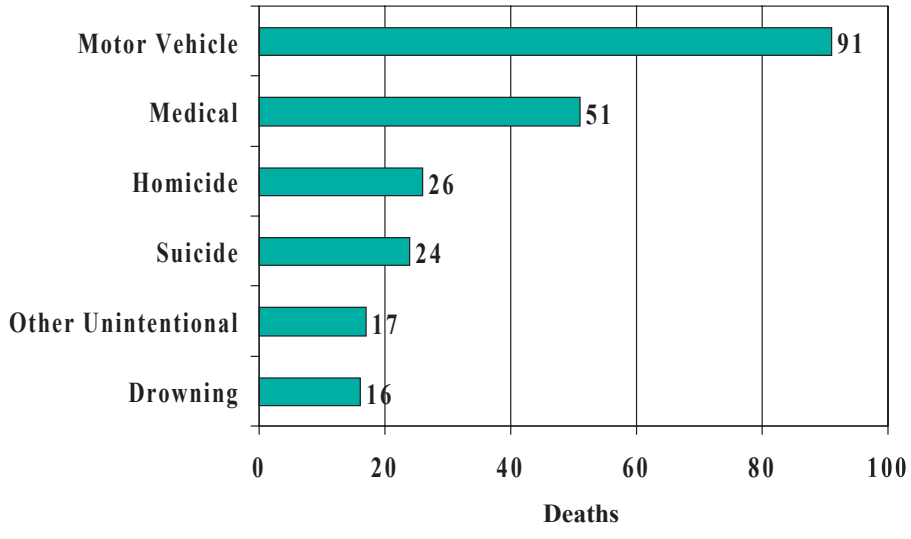
Findings

- 57% of deaths in this age group were caused by injuries
- 47% of those injuries were motor vehicle related, representing a decrease from 1999 (84)
- The total number of deaths dropped 15% (279 in 1999 to 237)

Figure 6. All Causes of Death, Age 15-17

Findings

- Deaths to older teens showed very little change in total or cause distribution from 1999
- 77% of all deaths were due to unintentional and intentional injuries
- 53% of injury related deaths are due to motor vehicle crashes



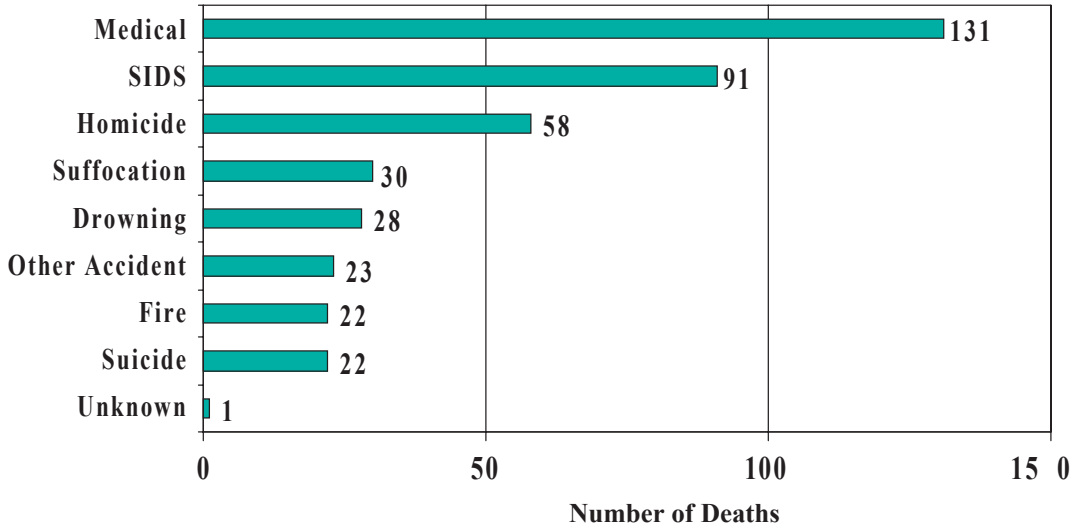
In 2000, 572 of the total 1,761 child deaths met the criteria requiring review according to death certificate data. Committees filed reports for 67% (381) of these deaths within the reporting period, representing a decline of 9% since calendar 1999. (The Panel attributes the decrease to a lack of resources available to local child fatality review committees for training and technical assistance during calendar year 2000.) Committees reviewed an additional 103 child deaths for a total of 484 deaths reviewed.

The distribution of child deaths in Georgia is generally proportional to the county population.

- Two hundred fifty-four (44%) of the reviewable child fatalities in 2000 occurred in 11 counties accounting for almost half of the population. While 188 of these deaths were reviewed (74%), three of the 11 counties reviewed only 2 of their combined 36 reviewable deaths
- The remaining 318 reviewable child fatalities were to children residing within 113 counties, and 193 of these deaths (61%) were reviewed. Thirty-seven of the 113 counties (33%) reviewed none of their reviewable deaths
- Eight counties had no child fatalities in 2000, and 27 had no child fatalities that met the review criteria

Four hundred six deaths, (injuries and SIDS), are discussed in the "Reviewed Deaths" sections of this report. Medical deaths are not included unless noted.

Figure7. Number of Reviewed Child Deaths by Cause



Finding

- Injuries due to motor vehicle incidents continued as a leading cause of death among children

Preventability

Each child fatality review report asks the team to determine whether the death could have been prevented. Only 14 (3%) of the 484 reports (all reviewed deaths) submitted in 2000 omitted this information. Of the remaining 470 (97%) reports addressing preventability, teams reported the following:

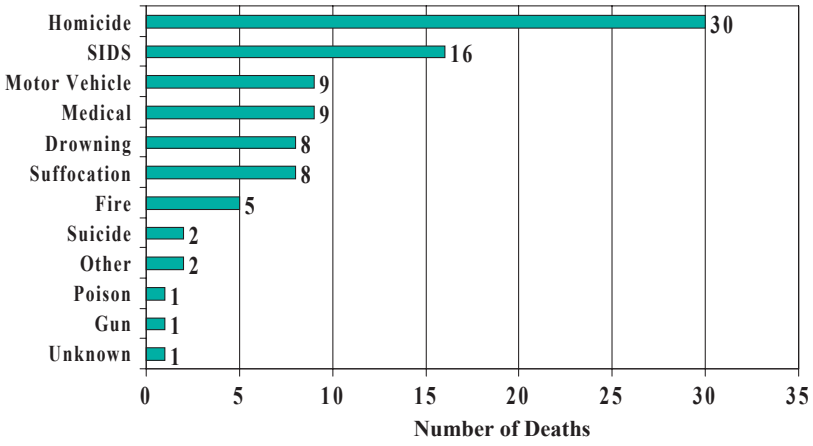
Definitely Preventable	34%
Possibly Preventable	41%
Not Preventable	25%

The extent to which a death is judged preventable by a committee depends on the cause of death and the age of the child (see Appendix C.4). Committees concluded that 63% (30/48) of the child deaths with confirmed child abuse were definitely preventable. In contrast, the proportion of definitely preventable deaths among those with no findings of abuse was less than half (30%).

Local Child Fatality Review Committees either suspected or confirmed child abuse or neglect in 92 (19%) of the 484 reviewed deaths. For 49 of those deaths (53%), abuse or neglect was confirmed. Data on maltreatment by age, gender and cause of death are included in Appendix C.3 of this report. The local Child Fatality Review Committees did not always agree with the cause of death stated on the death certificate, resulting in small differences in the numbers of abuse-related deaths in some categories. In this section, deaths are discussed using the committee's determination of cause of death.

Committees addressed the issue of whether there was a history of domestic violence in the home in 88 of the 92 child abuse/neglect related deaths. Nineteen percent (17) of those deaths indicated a history of domestic violence. Domestic violence was addressed in 378 reviewed deaths with no reported abuse or neglect, and 3% of those deaths indicated a domestic violence history.

Figure 8. Circumstances of Reviewed Deaths with Abuse/Neglect Findings

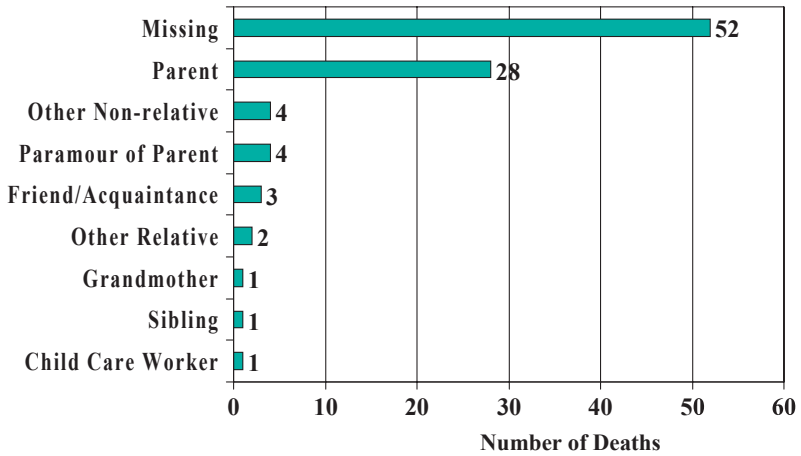


Findings

- 33% of reviewed deaths with child abuse or neglect findings were homicides
- Of the 30 homicides, 5 were confirmed as the result of Shaken Baby/Sudden Impact Syndrome, and another 6 were by firearms
- Local Child Fatality Review Committees suspected or confirmed abuse/neglect in 16 of the 91 SIDS deaths (17 percent). Seven of the 8 suffocation deaths with child abuse or neglect findings were to infants

Perpetrators

Figure 9. Relationship of Perpetrator to Decedent in Reviewed Cases with Abuse and Neglect

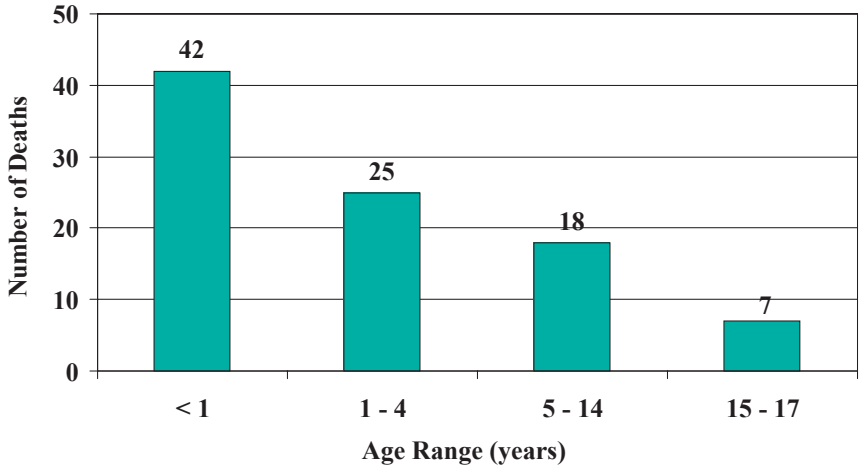


*Total = 44, reflecting 4 cases with 2 perpetrators identified.

Findings

- Local Child Fatality Review Committees identified perpetrators in 40 of the 92 deaths (44%)
- Among the identified 44 perpetrators, 64% (28) were the child's natural parent

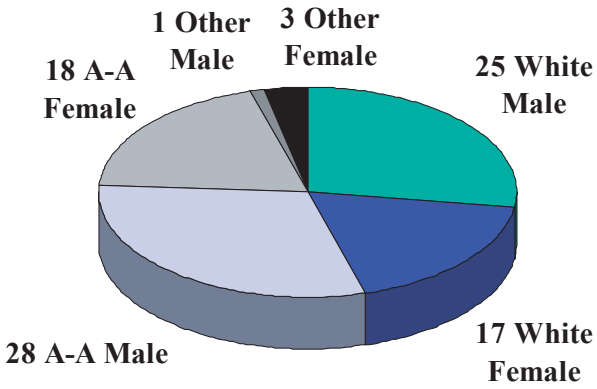
Figure 10. Age Distribution for Reviewed Deaths with Abuse or Neglect Findings



Findings

- 73% were under the age of 5
- 46% were under the age of 1

Figure 11. Reviewed Deaths with Abuse or Neglect Findings by Race and Gender



Findings

- 50% (46) of deaths were to African American children
- 59% (54) of deaths were to males and 30% were to African American males

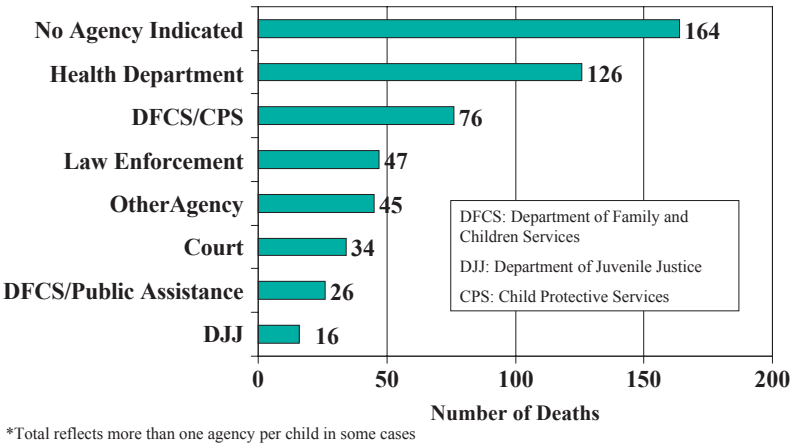
Opportunities for Prevention

- Promote prevention of child maltreatment as a community endeavor requiring the scrupulous adherence to proven prevention practices within all sectors of the community
- Expand home-based family support and visitation programs to prevent abuse and neglect
- Adopt a Child Endangerment law that penalizes adults who knowingly place children in dangerous situations and circumstances
- Authorize DFACS to access registry, law enforcement and court records regarding domestic violence in order to better assess the safety of children referred to their care
- Encourage Child Abuse Protocol Committees and Child Fatality Review Committees to take a proactive role in informing communities about prevention needs and successful prevention strategies

PRIOR AGENCY INVOLVEMENT

Sixty percent (289) of all 484 child fatality review reports received for 2000 indicated that one or more community agencies had prior interaction with the deceased child or his or her family. A designated list of agencies is provided on the reporting form, but child fatality review committees may add others as necessary. Agencies were not necessarily actively involved with children or families at the time of the deaths. The following figures list the agencies and the number of deaths in which they were identified. A child or family was often involved with more than one agency; therefore, the number of agencies exceeds the number of deaths.

Figure 12. Agency Involvement: Reviewed Deaths with No Child Abuse/Neglect Findings



*Total reflects more than one agency per child in some cases

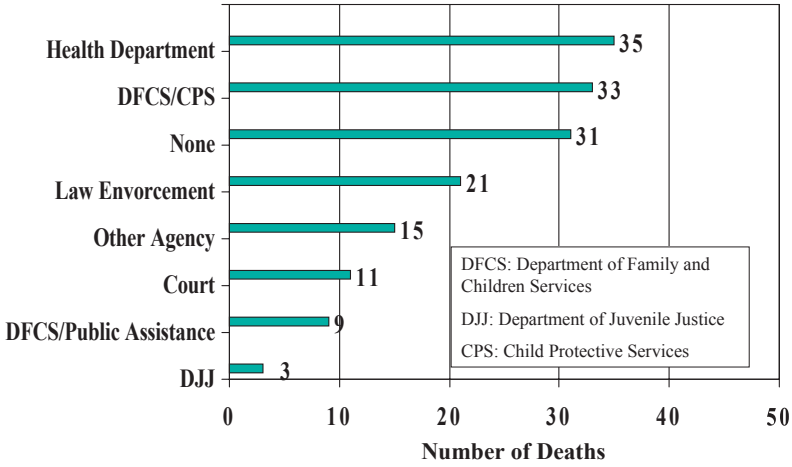
Findings

- 58% of deaths (228) had prior agency involvement
- Families had involvement with an average 1.6 agencies
- 45% of families had involvement with the Department Family & Children Services
- 55% of families had involvement with Public Health

Figure 13. Agency Involvement: Reviewed Deaths With Child Abuse/Neglect

Findings

- 66% of deaths (61) had prior agency involvement
- Families had involvement with an average 2.1 agencies
- 69% of families had involvement with the Department of Family & Children Services
- 57% of families had involvement with Public Health
- For the 33 children/families known to Child Protective Services, four reports did not indicate the nature of the involvement. For the remaining 29 children/families, involvement was as follows:



*Total reflects more than one agency per child in some cases

Decedent	7
Both decedent and another child in the family	10
Another child in the family, not the decedent	10
Decedent, another child in family, and caretaker	1
Caretaker	1

SUDDEN INFANT DEATH SYNDROME

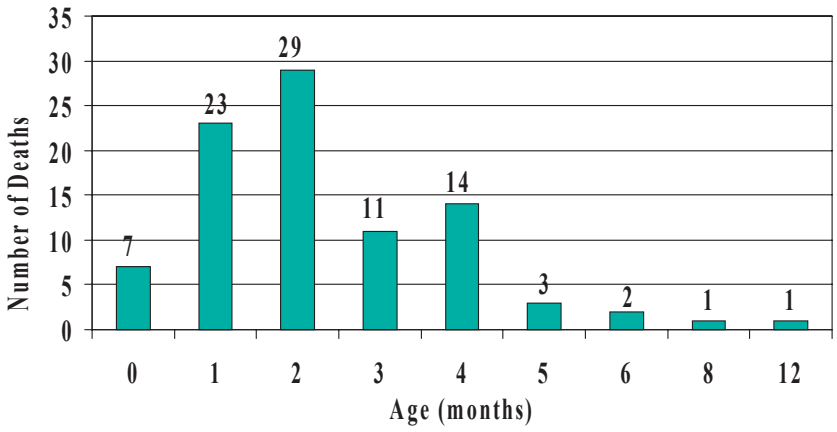
Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under one year of age that remains unexplained after performance of an autopsy, a thorough investigation of the death scene, and a review of the clinical history. SIDS is the most common cause of infant death among normal birthweight infants between one month and one year of age. It is estimated that at least 4,000 infants within the U.S. die as a result of SIDS each year.

SIDS continued to be a leading cause of infant deaths in Georgia. In 2000, death certificates listed 117 infant deaths as SIDS. Child fatality review committees reviewed 91 deaths that were determined to be SIDS.

Georgia law requires that an autopsy be completed for every SIDS death. Autopsies are a very critical component in accurately determining the cause of an infant's death, and differentiating other medical conditions and injuries from SIDS. Of the 91 deaths determined to be SIDS by child fatality review committees, autopsies were known to be completed for 86. Equally important are death scene investigation findings which provide critical guidance for autopsies. Ninety (90) death scene investigations were completed for the 91 reviewed SIDS deaths.

Child fatality review committees reviewed several infant deaths that related to "bed-sharing". Bed-sharing is a term used to describe an infant sleeping in the same bed with one or more individuals. Committees identified bed-sharing as an increased risk for suffocation of infants that could be mistaken for SIDS.

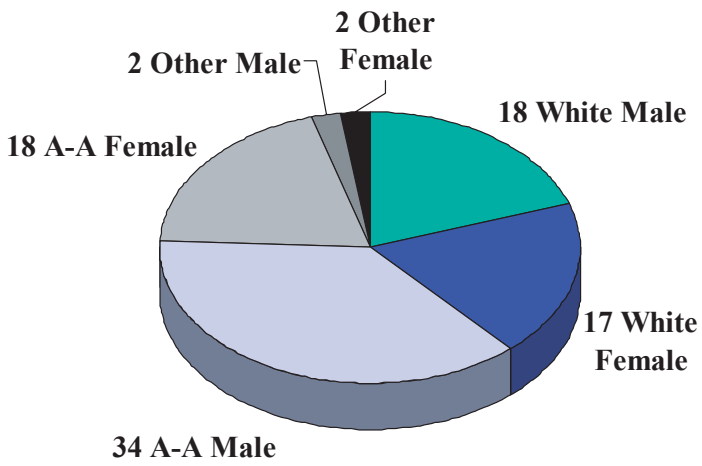
Figure 14. Reviewed SIDS Death by Age



Finding

• 77% (70) of SIDS deaths occurred among infants 0 to 3 months of age.

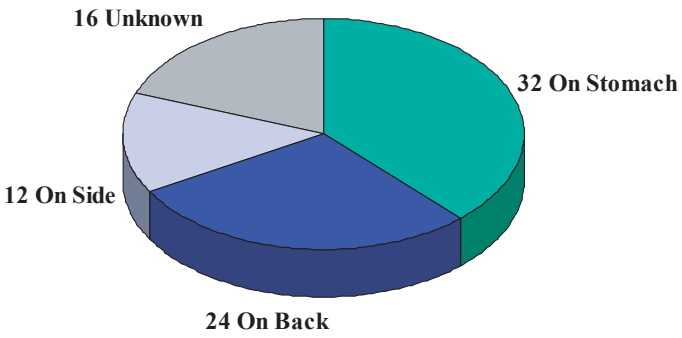
FIGURE 15. Reviewed SIDS Death by Race and Gender



Findings

• 57% (52) of SIDS victims were African-American
• 59% (54) of SIDS victims were male

FIGURE 16. Sleeping Position of Infants Who Died of SIDS



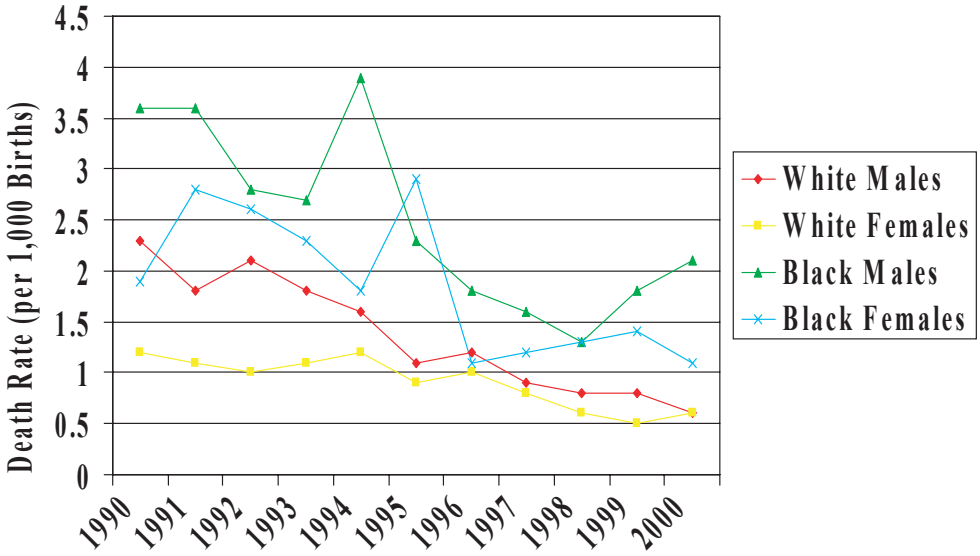
* 7 cases did not include any information on sleeping position

Findings

- Committees responded to the question regarding sleep position for 84 SIDS deaths. Sleep position was known in 81% (68) of those deaths
- 47% of the victims were reported to be sleeping on their stomachs, and 35% were reported to be sleeping on their backs

SIDS TRENDS

Figure 17. SIDS Deaths Rates Per 1,000, Age <1, 1990-2000



Findings

- The total number of SIDS deaths was essentially unchanged from 1999 to 2000 (an increase from 116 to 117). There have been an average of 117 SIDS per year for the past five years. There were an average of 165 SIDS deaths per year for the preceding five years. A portion of this decline is likely due to the "Back to Sleep" campaign, but the decrease has not continued
- The Georgia SIDS data show consistent race and gender effects. Rates remain higher among African American infants (of both sexes) than among white infants, and African American male infants are almost four times more likely than a white male infant to be a victim of SIDS. The number of African American, male SIDS deaths has increased from 27 in 1998 to 47 in 2000

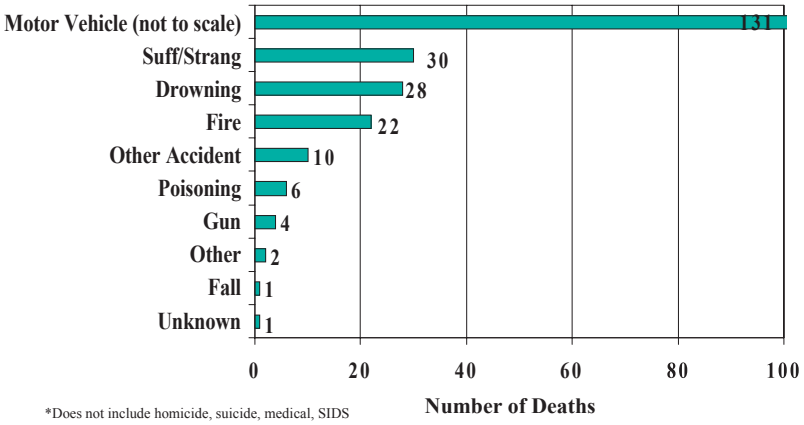
Opportunities for Prevention

- Educate the public (targeting African American communities) about risk reduction including back sleeping, breastfeeding, prenatal smoking cessation, smoke free environment and use of firm bedding materials
- Incorporate risk reduction information in prenatal education for expectant parents
- Promote a statewide public education program on the risks of overlay when bed-sharing

UNINTENTIONAL INJURY RELATED DEATHS

According to death certificate data, injuries were responsible for 455 child deaths. Three hundred forty-nine (349) of those deaths were unintentional. Child fatality review committees reviewed 235 injury related deaths determined to be unintentional. Figure 18 shows the distribution of those deaths by type of injury. Committees could not determine the manner of death in 3 instances.

Figure 18. Reviewed Unintentional Injury-Related Deaths by Cause



*Does not include homicide, suicide, medical, SIDS

Findings

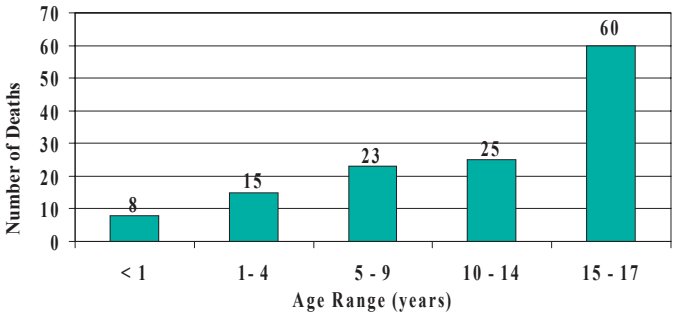
- 56% of deaths resulted from motor vehicle-related incidents
- 34% (80) of injury-related deaths occurred among children under the age of 5
- Although there were fewer reviewed cases in 2000 than 1999, fire deaths increased 120% from 1999 (10)

MOTOR VEHICLE–RELATED DEATHS

It is estimated that children 0-17 are more likely to die from a motor vehicle-related injury than any other injury. Motor vehicle incidents continue to be the leading cause of death among teens 15-17 and the second leading cause of death to children between ages 1-15 in Georgia. Death certificate data indicated that 195 child deaths resulted from motor vehicle incidents. Child fatality review committees reviewed 131 child deaths that were related to motor vehicle incidents.

Of the 131 reviewed motor vehicle-related deaths, 84 (64%) involved children who were passengers, and 32 (24%) were operators of cars, trucks, RVs, or vans. Information on the presence of restraints was provided for 128 of the reviewed deaths. It was determined that restraints were not used in 30 (41%) incidents in which a vehicle was known to be equipped with a restraint (74). The remaining 12% of the 131 reviewed motor vehicle-related deaths involved bicycles (4), all terrain vehicles (7), motorcycles (1), school buses (3), and a tractor (1). Of the 11 deaths involving bicycles and all terrain vehicles, 5 children were not wearing safety helmets.

FIGURE 19.
Reviewed Motor Vehicle-Related Deaths by Age

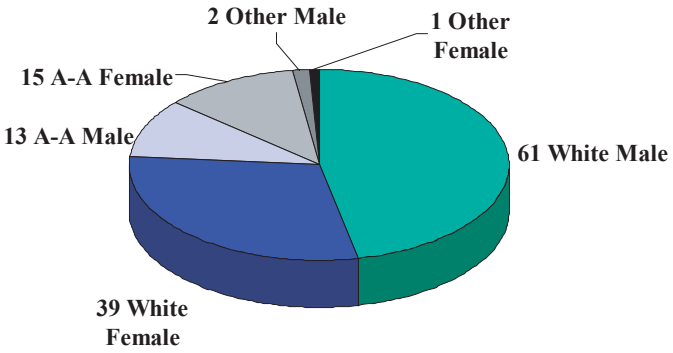


Findings

- 46% of reviewed motor vehicle-related deaths occurred among teens ages 15-17
- As teens achieved legal driving age, the number of deaths increased as follows:

Age 15	9 deaths
Age 16	29 deaths
Age 17	22 deaths

Figure 20. Reviewed Motor Vehicle-Related Deaths by Race and Gender

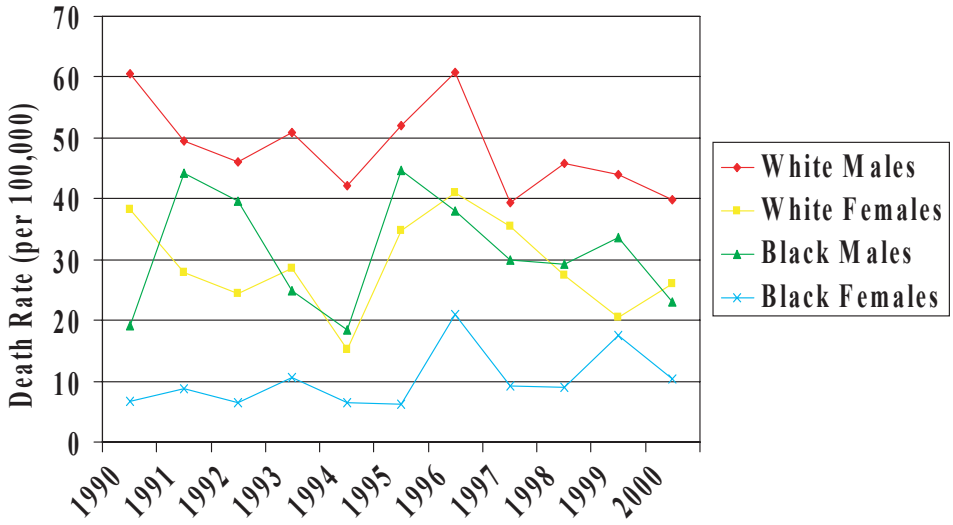


Findings

- 76% (100) of deaths were white children, up from 64% in 1999
- 58% (76) of deaths were male children, down from 67% in 1999

Motor Vehicle Trends

Figure 21. Motor Vehicle Fatality Rates per 100,000: Age 15-17, 1990-2000



Findings

- The total number of MV fatalities for 15-17 year olds decreased slightly (from 99 to 91) from 1999 to 2000. (The total number of deaths among 15 to 17 year olds from all causes was essentially unchanged –228 to 225)
- Motor vehicle crashes remain the leading cause of death among teens 15 to 17. All other accidental or violent deaths only total 80 deaths in this age group
- There was no change in the total number of MV crash deaths among white teens; but the total number of deaths among teens decreased by 1/3 (from 30 to 20)

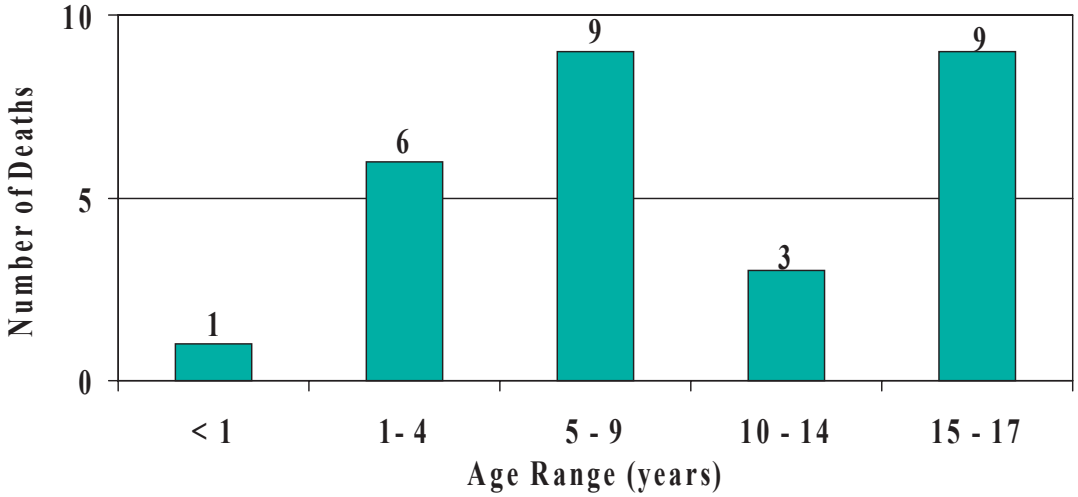
Opportunities for Prevention

- Enforce the Teenage and Adult Driver Responsibility Act
- Support statewide availability of driver education programs
- Continue to promote bicycle helmet use including education about proper fit and wearing position
- Promote educational programs for parents and caregivers in settings such as hospitals, child care centers and health departments to teach proper installation and use of car seats and proper use of vehicle restraints
- Encourage communities to provide car seats to families with infants and young children who need financial assistance to purchase safe equipment
- Encourage pedestrian safety campaigns

Drowning

According to death certificate data, 47 children died as a result of drowning which was an 11% decrease from 1999 (53). Child fatality review committees reviewed 28 drowning deaths of children under the age of 18 years. Of the 27 cases where flotation device information was indicated, only two (both swimming in pools) were wearing a flotation device.

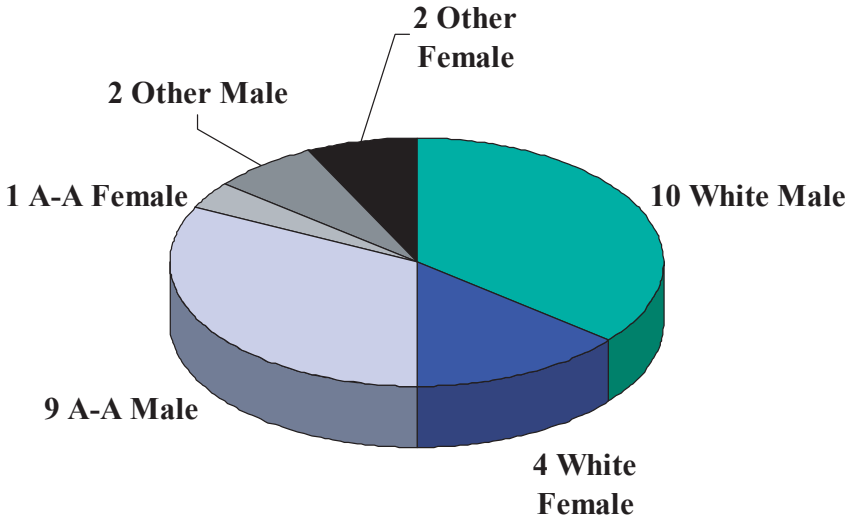
Figure 22. Reviewed Deaths Due to Drowning by Age



Finding

• 43% of drowning victims were children between the ages of 5 and 14

Figure 23. Reviewed Drowning Deaths by Race and Gender

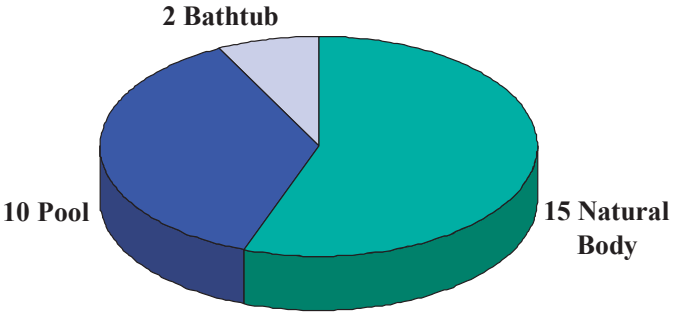


Finding

• Three times as many drowning deaths occurred among males as females

Drowning Trends

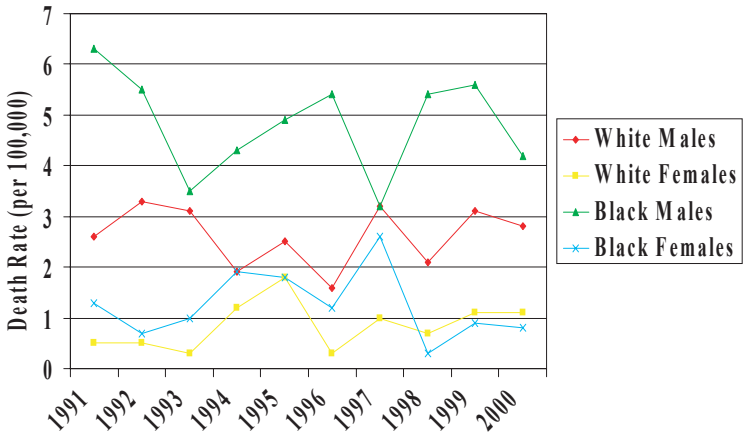
Figure 24. Place of Drowning



Findings

- 56% of drowning victims died in a natural body of water
- The total number of drowning deaths in pools decreased from 1999 (16) to 2000 (10)
- Drowning deaths in bathtubs also showed a slight decrease from 1999 (4) to 2000 (2)

Figure 25. Drowning Fatality Rates per 100,000: Age < 18, 1990-2000



Findings

- The total number of drowning deaths decreased from 53 in 1999 to 47 in 2000. The major change was a drop in male drowning deaths from 42 to 35. There was one more female drowning death in 2000 than in 1999
- Total child drowning deaths have remained fairly constant over the past ten years, with an average of 43 per year. The annual numbers fluctuate, but there are no apparent trends. Black males have consistently had the highest rates

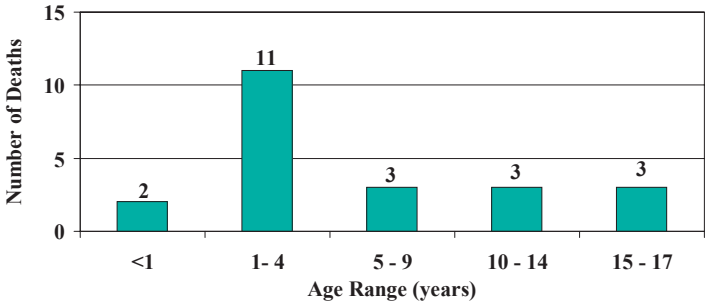
Opportunities for Prevention

- Increase public education efforts that teach water safety and skills, among school age children
- Promote regulations and enforcement to limit alcohol use by operators of recreational boats
- Encourage Department of Natural Resources to establish stronger rescue capabilities at state swimming facilities
- Enact and enforce statewide ordinances related to fences and gates in public and private swimming pools

Fire Related Deaths

Death certificate data indicated a total of 26 fire-related deaths that represent an increase from 1999 (10). Child fatality review committees reviewed 22 fire-related deaths in 2000. According to committees, in several incidents, a single fire caused multiple child deaths.

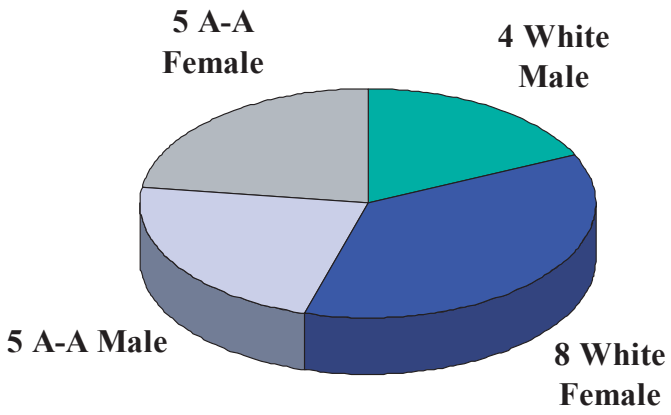
Figure 26. Reviewed Deaths Due to Fire by Age



Findings

- Reviewed fire deaths increased from 10 in 1999 to 22 in 2000 (120%)
- A majority of the victims of fire-related deaths (73%) were under the age of 10

Figure 27. Reviewed Deaths Due to Fire by Race and Gender

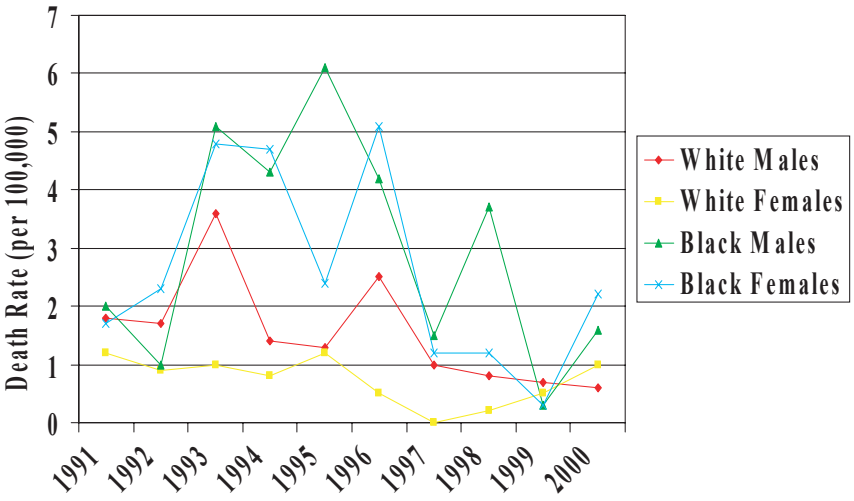


Finding

- There were almost equal numbers of fire-related deaths among whites (12) and African-Americans (10)

Fire-Related Trends

Figure 28. Fire-Related Fatality Rates per 100,000 Ages < 18, 1990-2000



Findings

- After a decade low of 10 fire related deaths in 1999, there were 26 deaths in 2000. This increase was due to an increase in the number of black victims from 2 to 14. However, the average number of deaths (18.5) for the past four years ('97 to '2000) is less then half of the average number (41) for the preceding seven years
- These numbers suggest a "real" improvement in the prevention of deaths due to fire and not just statistical fluctuations

Opportunities for Prevention

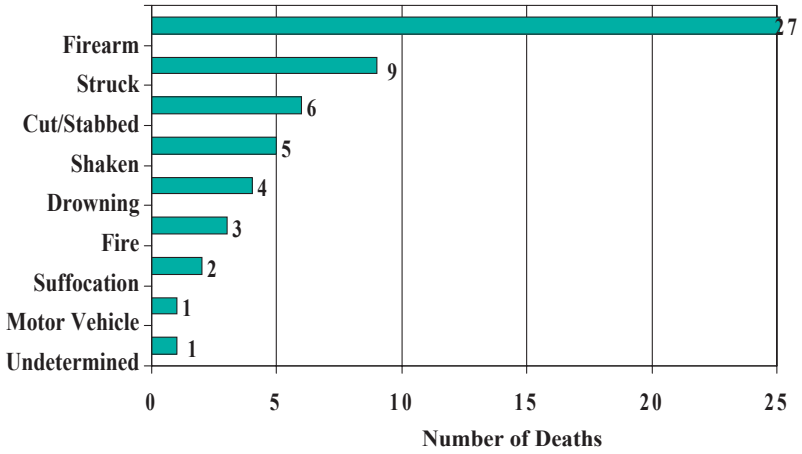
- Continue and expand school fire safety programs that teach critical messages like "stop, drop and roll" and those that help families plan fire escape routes
- Continue and expand community programs to provide smoke detectors and batteries to families who can not afford them
- Promote public education about the importance of changing smoke detector batteries every six months

In 2000, local Child Fatality Review Committees determined a total of 80 deaths (58 homicides and 22 suicides) to be the result of intentional injuries. Using death certificate data, the total number of deaths resulting from homicide and suicide (106) increased by nearly 13% since 1999. Thirty of the 92 deaths reported by child fatality review committees with findings of abuse or neglect were homicides.

Homicide

Child Fatality Review Committees reported 58 homicide deaths. The figure below presents reviewed homicide deaths by circumstance of death.

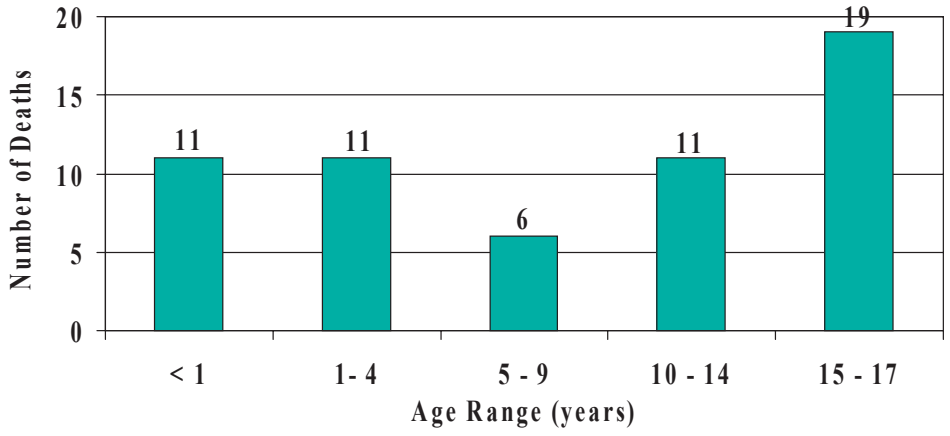
Figure 29 Reviewed Homicide Deaths by Circumstance of Death



Findings:

- Firearms were the cause of 47% of all reviewed homicides (27 deaths)
- 26% of homicide deaths (15 deaths) were due to injuries resulting from being struck or stabbed.

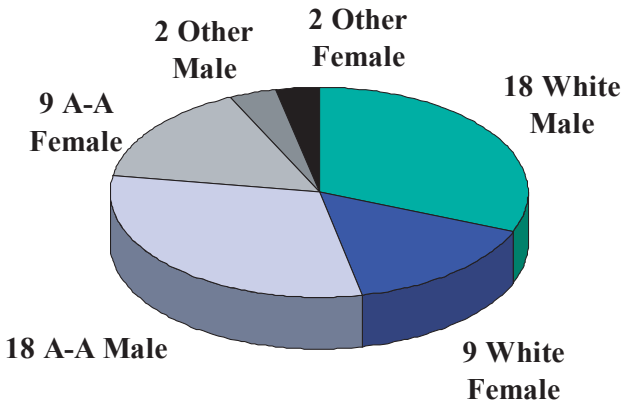
Figure 30. Reviewed Homicide Deaths by Age



Findings:

- Children under five years of age were 38% of all reviewed homicide deaths
- Teenagers aged 15-17 years were 33% of all reviewed homicides

Figure 31. Reviewed Homicide Deaths by Race and Gender

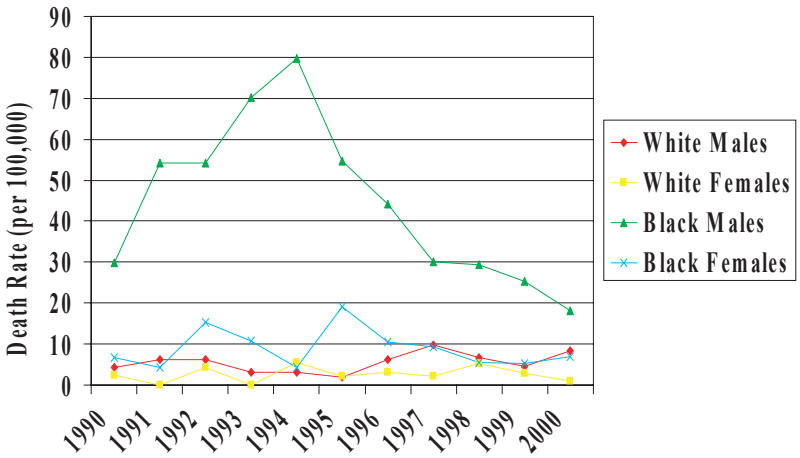


Findings

- 66% of homicide victims were male, with an equal number of African American and white males. However, the rate among African American males is approximately twice the rate among white males (see figure 32)
- 47% of homicide victims were African American compared to 69% in 1999

Homicide Trends

Figure 32. Death Rates for Teen Homicides per 100,000, Ages 15-17, 1990-2000



Findings

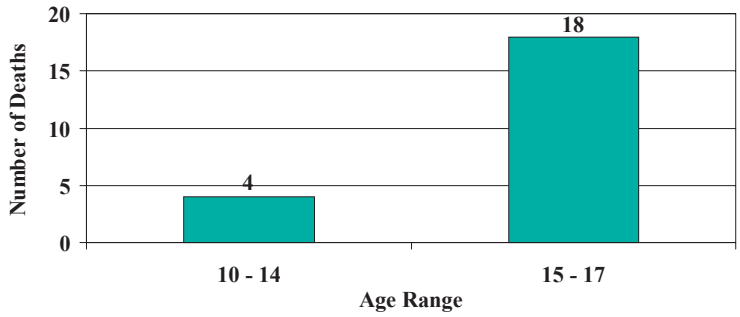
- The total number of teen homicides (26) were unchanged from 1999 to 2000
- Homicides among African American males continues at a disproportionately high rate, but has been declining steadily since 1994

Opportunities for Prevention

- Promote school and after-school programs teaching conflict resolution, impulse control, anger management and empathy
- Increase the availability of community-based parenting education including positive discipline techniques
- Support legislation promoting responsible gun ownership including use of firearm safety locks and safe firearm storage

In 2000, local Child Fatality Review Committees reviewed 22 deaths of children who took their own lives. Death certificate data indicated a total of 30 suicide deaths. Firearms were used in 59% (13) of reviewed suicides. Strangulation (hanging) was the circumstance of death for another 7 reviewed deaths. Two deaths resulted from poisoning.

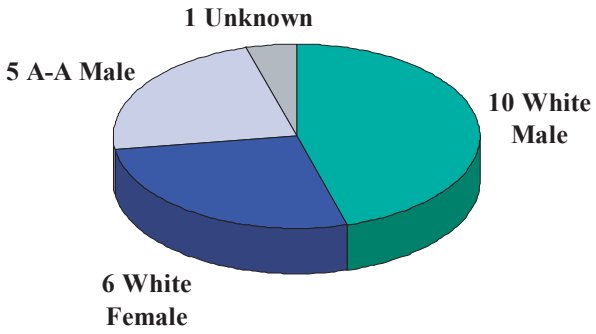
Figure 33. Reviewed Suicide Deaths by Age



Findings

- 82% of reviewed suicide deaths occurred to teens 15-17
- The youngest reviewed suicide victim (12 years old), died of injuries sustained from strangulation due to hanging

Figure 34. Reviewed Suicide Deaths by Race and Gender



Findings

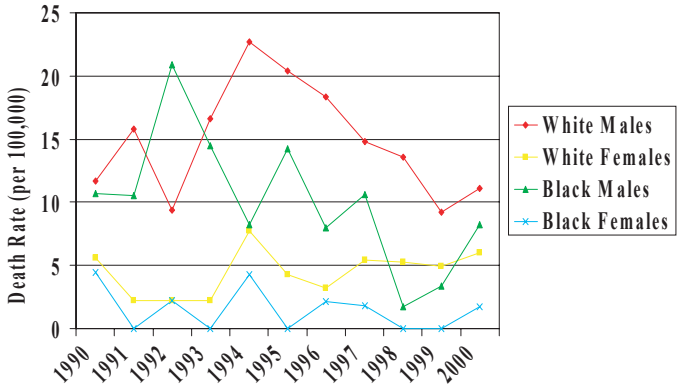
- 73% of all reviewed suicide victims were white children
- 68% of all reviewed suicide victims were males
- 45% of all reviewed suicide victims were white males

Suicide Trends

Figure 35. Suicide Death Rates per 100,000, Ages 15-17, 1990-2000

Findings

- There were slight increases in all race/gender categories for teen suicides in 2000. The total number rose from 17 to 24 with African-American male suicides increasing from two to five
- The average number of suicide deaths for all age groups under 18 was 30 per year for the past five years, a decline from 35 per year for the preceding five years



Opportunities for Prevention

- Increase the access and availability of mental health and substance abuse prevention and treatment services to children and youth
- Increase awareness of suicide warning signs among parents, caretakers and communities, and promote prompt action when warning signs are recognized
- Develop community intervention resources for children at risk of suicide
- Advocate for safe home storage of firearms

FIREARM DEATHS

Forty-four of the deaths reviewed by Child Fatality Review Committees were caused by firearms. Firearm deaths include homicides, suicides and unintentional injuries. Death certificate data indicated a total of 45 deaths resulting from firearms in 2000, a decrease from the 51 such deaths recorded in 1999. Child fatality review reports ask for information not available on death certificates including source of the firearm, type of firearm, who was using the firearm at the time of death and the age of the firearm handler. This information provides important guidance for prevention.

Figure 36. Reviewed Firearm Deaths by Circumstance of Death

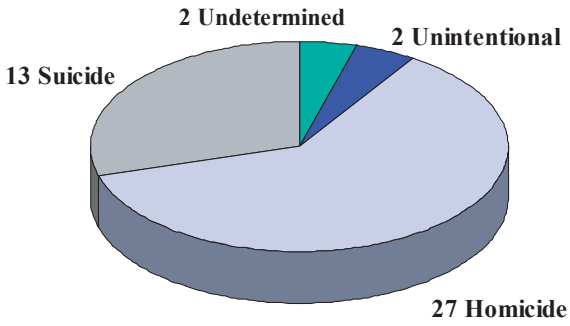
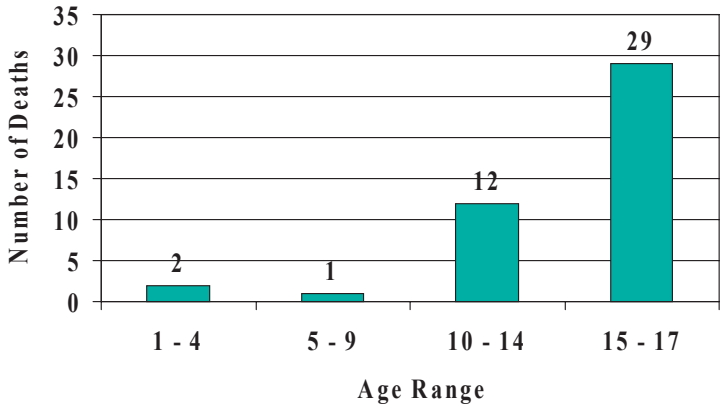


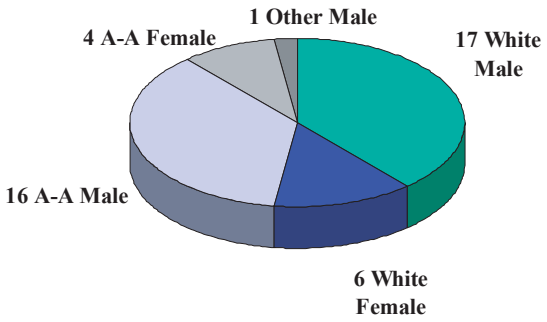
Figure 37. Reviewed Firearm Deaths by Age



Findings

- 66% of reviewed firearm deaths occurred to children aged 15-17
- Of reviewed firearm deaths among 15-17 year olds, 55% (16) were homicides and 38% (11) were suicides

Figure 38. Reviewed Firearm Deaths by Race and Gender



Findings

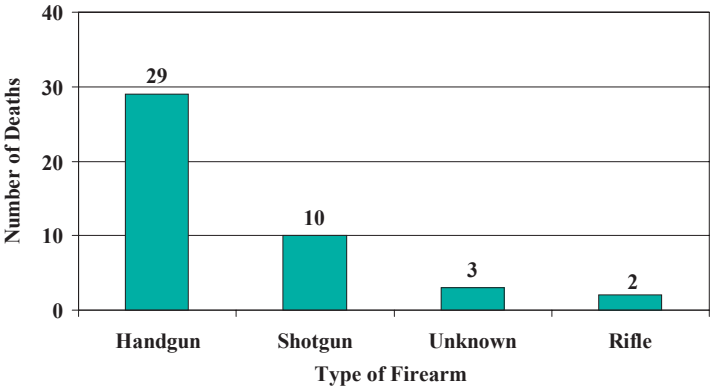
- 45% of reviewed firearm deaths occurred to African American children
- 77% of reviewed firearm deaths were to males

Source of Firearm

- In 51% [50%] (22) of reviewed firearm deaths, the firearm was obtained from someone the child knew (a parent, other relative or acquaintance)
- Parents were the source of the firearm in 9 of the 13 reviewed suicides by firearm
- The source of the firearm was unknown in 42% [43%] (19) of reviewed firearm related deaths
- Strangers unknown to the child provided the firearm used in 3 deaths

Type of Firearm

Figure 39. Reviewed Firearm Deaths by Type of Firearm



Findings

- 66% (29) of the firearms were handguns compared to 77% in 1999
- 23% (10) of the firearms were shotguns. There were no shotgun deaths reviewed in 1999
- Of the 22 reviewed suicide deaths, 59% (13) were committed with a firearm. Of these, 10 deaths (77%) involved a handgun, and 3 deaths (23%) involved a shotgun
- Of the 58 reviewed homicides, 47% (27) were committed with a firearm. Of these, 15 deaths (56%) involved handguns, 7 (26%) involved shotguns, an additional two involved a rifle, and 3 listed firearm type as unknown

Usage

- 84% of the time (37 deaths) the shooter was aiming at himself or at someone else
- Two deaths were the result of the shooter "playing" with the firearm

Storage

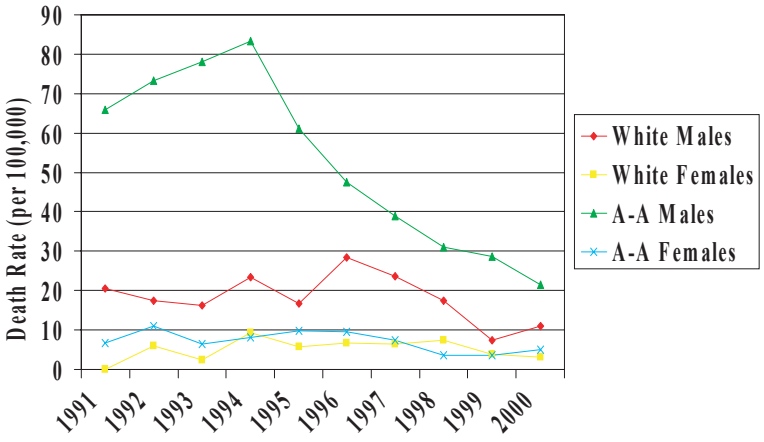
- Storage of the firearm was indicated in 41 of the 44 reviewed firearm deaths. Of those, 66% (27) indicated the storage location of the firearm prior to the death was unknown
- In 64% (9) of the reviewed firearm deaths in which the storage location was known (41 cases), the firearm had not been secured to prevent use by children or unauthorized adults

Age of Handler

- The shooter was under the age of 15 in both of the unintentional deaths
- When the age of the handler was known (35 cases), 66% were under the age of 18

Firearm Trends

Figure 40. Firearm Death Rates per 100,000, Ages 15-17, 1990-2000



Findings

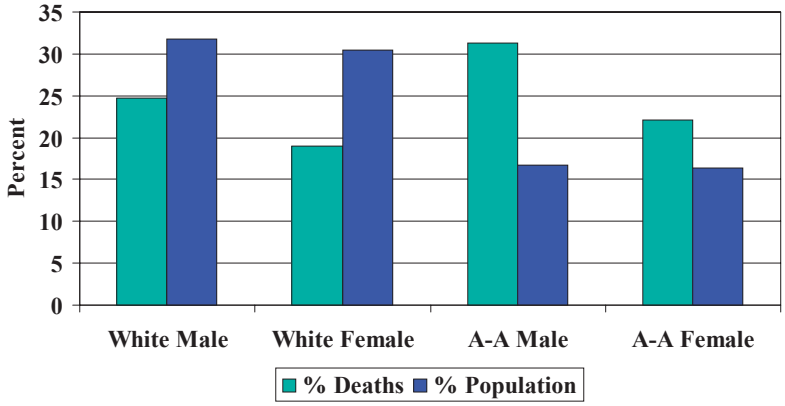
- There was little change in firearm deaths from 1999 (31) to 2000 (32). Deaths among white males increased by four and decreased by four among African American males
- While rates for African American males remain disproportionately high, firearm related deaths are at their lowest point in a decade

Opportunities for Prevention

- Promote school and community-based risk reduction and firearm safety programs for children, parents and other caretakers
- Promote the use of firearm safety devices, including trigger locks
- Support efforts to limit minors' access to firearms

Data are presented in this report by race and gender for each type of death to enable more detailed analysis. The terms "White", "African-American" (A-A) and "Other" are used to identify racial groups throughout the report. "Other" refers to children of Asian, Pacific Islander, or Native American origin. Death certificate data includes ethnicity information that can identify children of Hispanic origin. Eighty of 85 deaths identified as Hispanic indicated the race as "White." Three deaths identified as Hispanic indicated African-American as the race, and the remaining 2 indicated the race to be Other.

Figure 41. Deaths to Children < 1 and Percent of Population in Georgia By Race and Gender



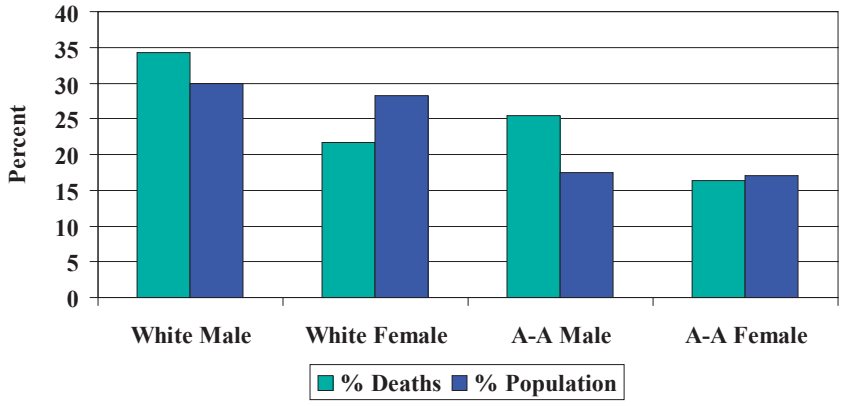
Findings

- A disproportionate number of deaths occurred among African-American infants

	% of Deaths	% of Population
All A-A Infants	56.1	32.2
A-A-Male Infants	31.7	16.4
A-A Female Infants	24.4	15.8

- The infant mortality rate for African-American infants (11.5 per 1,000 births) was more than double the rate for white infants (5.0 deaths per 1,000 births)

Figure 42. Deaths to Children 1-17 and Percent of Population in Georgia, By Race and Gender



Findings

- A disproportionate number of deaths occurred among male children
- Males between the ages of 1 and 17 are about 50% more likely to die than females in the same age range

	% of Deaths	% of Population
All Males 1 – 17	60.7	51.2
AA-Males 1 – 17	25.4	17.5
White Males 1 - 17	34.2	30.0

THE HISTORY OF CHILD FATALITY REVIEW IN GEORGIA

1990 - 1993

Legislation established the Statewide Child Fatality Review Panel with responsibility for compiling statistics on child fatalities and for making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols for the investigation of alleged child abuse and neglect cases. Statutory amendments were adopted to:

- Establish a separate child fatality review team in each county and determine procedures for conducting reviews and completing reports
- Change the name of the Statewide Child Fatality Review Panel to the Statewide Child Abuse Prevention Panel and require the Panel to:
- Submit an annual report documenting the prevalence and circumstances of all child fatalities with special emphasis on deaths associated with child abuse
- Recommend measures to reduce child fatalities to the Governor, the Lieutenant Governor, and the Speaker of the Georgia House of Representatives
- Establish a protocol for the review of policies, procedures and operations of the Division of Family and Children Services for child abuse cases
- Monitor implementation of the State Child Abuse Prevention Plan

1996 - 1998

- The Statewide Child Abuse Prevention Panel established the Office of Child Fatality Review with a full-time director to administer the activities of the Panel
- An evaluation of the child fatality review process was conducted by researchers from Emory University and Georgia State University. The evaluation concluded that there were policy, procedure, and funding issues that limited the effectiveness of the review process. Recommendations for improvement were made to the General Assembly
- Statutory amendments were adopted to:
  - Identify agencies required to be represented on child fatality review teams, and establish penalties for non-participation
  - Require that all child deaths be reported to the coroner/medical examiner in each county
  - Establish additional requirements for county child fatality review committees

1999 - 2001

- Child death investigation teams were initially developed in four judicial circuits as a pilot project, with six additional teams later added. Team members were identified as law enforcement, coroner or medical examiner, district attorney representative, and department of family and children services representative. Teams assumed responsibility for conducting death scene investigations of child deaths within their judicial circuit that met established criteria
- Statutory amendments were adopted which resulted in the Code section governing the Child Fatality Review Panel, child fatality review committees, and child abuse protocol committees being completely rewritten. This was an attempt to provide greater clarity and a more comprehensive, concise format. The name of the Statewide Child Abuse Prevention Panel was changed to the Georgia Child Fatality Review Panel
- The Panel's budget was increased to allow for 1 additional staff person, and establishment of physical office space.

APPENDIX A
CRITERIA FOR CHILD DEATH REVIEWS

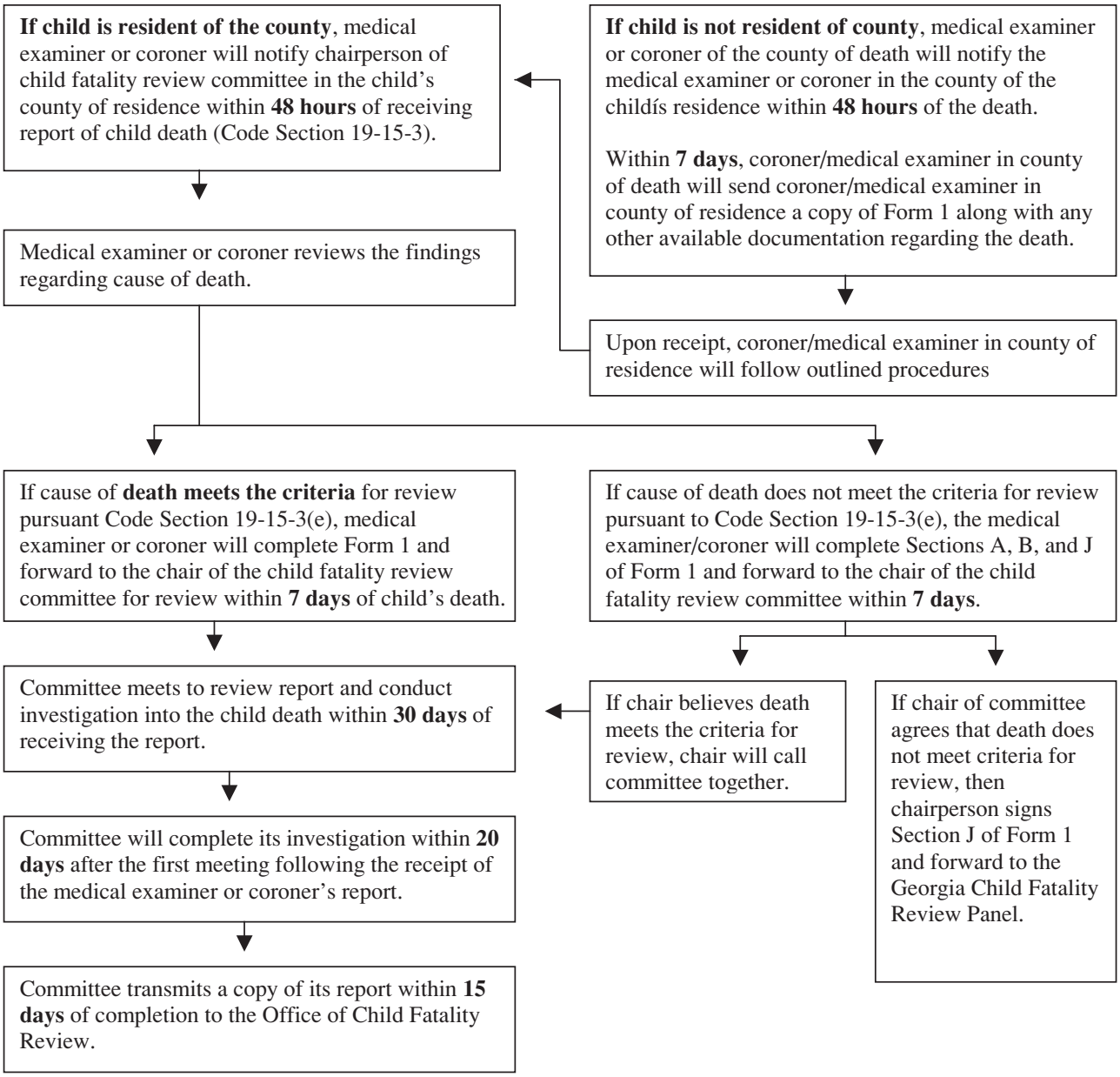
Child Fatality Review Teams are required to review the deaths of all children under the age of 18 that meet the criteria for a coroner/medical examiner's investigation.

"Eligible" Deaths or Deaths to be Reviewed by Child Fatality Review Teams O.C.G.A. 19-15-3(e)

The death of a child under the age of 18 must be reviewed when the death is *suspicious, unusual, or unexpected*. Included in this definition are incidents when a child dies:

1. as a result of violence
2. by suicide
3. by a casualty (i.e., car crash, fire)
4. suddenly when in apparent good health
5. when unattended by a physician
6. in any suspicious or unusual manner, especially if under 16 years of age
7. after birth but before seven years of age if the death is unexpected or unexplained
8. while an inmate of a state hospital or a state, county, or city penal institution
9. as a result of a death penalty execution

APPENDIX B
CHILD FATALITY REVIEW TIMEFRAMES AND RESPONSIBILITIES



Send copy of the report within **15 days** to district attorney of the county in which the committee was created if the report concludes that the death was a result of: SIDS without confirmed autopsy report; accidental death when death could have been prevented through intervention or supervision; STD; medical cause which could have been prevented through intervention by agency involvement or by seeking medical treatment; suicide of a child under the custody of DHR or when suicide is suspicious; suspected or confirmed child abuse; trauma to the head or body; or homicide.

APPENDIX C.1 Total Child Fatalities Based on Death Certificate

			White		Black		Other		
Infant (Age < 1)	Cause of Death	Missing	Male	Female	Male	Female	Male	Female	Total
	Drowning	0	0	1	0	1	0	0	2
	Fire / Burns	0	0	1	0	2	0	0	3
	Poisoning	0	1	0	2	0	0	0	3
	Suffocation	0	8	6	5	4	1	0	24
	Vehicle Crashes	0	4	5	2	3	0	0	14
	Other	0	1	1	0	2	0	1	5
	Homicide	0	4	2	6	2	0	0	14
	SIDS (All)	0	24	23	47	23	0	0	117
	Medical Causes	2	233	180	296	209	15	8	943
	Total	2	275	219	358	246	16	9	1,125

			White		Black		Other		
Ages 1 to 4	Cause of Death	Missing	Male	Female	Male	Female	Male	Female	Total
	Drowning	0	7	3	2	0	1	0	13
	Fire / Burns	0	2	1	3	3	0	2	11
	Poisoning	0	1	0	0	0	0	0	1
	Suffocation	0	5	2	0	0	0	1	8
	Vehicle Crashes	0	13	3	4	6	0	0	26
	Other	0	1	0	3	2	0	0	6
	Homicide	0	4	4	3	5	0	0	16
	Medical Causes	0	28	22	21	20	0	2	93
	Total	0	61	35	36	36	1	5	174

			White		Black		Other		
Ages 5 to 14	Cause of Death	Missing	Male	Female	Male	Female	Male	Female	Total
	Drowning	0	2	3	7	2	0	2	16
	Fire / Burns	0	2	2	2	3	0	0	9
	Suffocation	0	2	0	4	0	0	0	6
	Vehicle Crashes	0	23	19	6	13	1	2	64
	Other	0	4	7	2	1	0	0	14
	Homicide	0	6	3	7	3	1	0	20
	Suicide	0	4	1	1	0	0	0	6
	Medical Causes	0	38	21	27	14	2	0	102
	Total	0	81	56	56	36	4	4	237

			White		Black		Other		
Ages 15 to 17	Cause of Death	Missing	Male	Female	Male	Female	Male	Female	Total
	Drowning	0	9	0	7	0	0	0	16
	Fire / Burns	0	0	2	1	0	0	0	3
	Poisoning	0	1	1	1	0	0	0	3
	Suffocation	0	1	0	0	0	0	0	1
	Vehicle Crashes	0	43	26	14	6	2	0	91
	Other	0	2	1	4	3	0	0	10
	Homicide	0	9	1	11	4	1	0	26
	Suicide	0	12	6	5	1	0	0	24
	Medical Causes	0	18	10	10	10	1	2	51
	Total	0	95	47	53	24	4	2	225

APPENDIX C.2 Total Reviewed Child Fatalities

		White		Black		Other		
Infant (Age < 1)	Cause of Death	Male	Female	Male	Female	Male	Female	Total
	Drowning	0	1	0	0	0	0	1
	Fire / Burns	0	1	0	1	0	0	2
	Homicide	3	2	3	1	1	1	11
	Medical Causes	6	5	12	8	1	0	32
	Vehicle Crashes	2	4	1	1	0	0	8
	Other Accidents	0	1	0	1	0	0	2
	Poisoning	1	0	1	0	0	0	2
	SIDS	18	17	34	18	2	2	91
	Suffocation	8	3	4	2	0	1	18
	Total	38	34	55	32	4	4	167

		White		Black		Other		
Ages 1 to 4	Cause of Death	Male	Female	Male	Female	Male	Female	Total
	Drowning	4	1	0	0	1	0	6
	Fire / Burns	2	3	3	3	0	0	11
	Firearm	0	0	0	1	0	0	1
	Homicide	3	4	1	2	0	1	11
	Medical Causes	6	1	3	6	1	1	18
	Vehicle Crashes	9	2	2	2	0	0	15
	Other	0	0	1	1	0	0	2
	Other Accidents	0	0	1	1	0	0	2
	Poisoning	1	0	0	0	0	0	1
	Suffocation	4	3	0	0	0	1	8
	Unknown	0	0	1	0	0	0	1
	Total	29	14	12	16	2	3	76

		White		Black		Other		
Ages 5 to 14	Cause of Death	Male	Female	Male	Female	Male	Female	Total
	Drowning	1	2	5	1	1	2	12
	Fall	0	0	1	0	0	0	1
	Fire / Burns	2	2	1	1	0	0	6
	Firearm	1	0	0	0	0	0	1
	Homicide	6	3	5	3	0	0	17
	Medical Causes	6	6	2	2	0	0	16
	Vehicle Crashes	21	14	3	9	0	1	48
	Other	0	0	0	0	0	0	0
	Other Accidents	1	3	0	0	0	0	4
	Suffocation	2	0	1	0	0	0	3
	Suicide	2	1	1	0	0	0	4
	Total	42	31	19	16	1	3	112

		White		Black		Other		
Ages 15 to 17	Cause of Death	Male	Female	Male	Female	Male	Female	Total
	Drowning	5	0	4	0	0	0	9
	Fire / Burns	0	2	1	0	0	0	3
	Firearm	1	0	1	0	0	0	2
	Homicide	6	0	9	3	1	0	19
	Medical Causes	1	1	5	3	0	2	12
	Vehicle Crashes	29	19	7	3	2	0	60
	Other Accidents	0	0	0	2	0	0	2
	Poisoning	0	2	1	0	0	0	3
	Suffocation	1	0	0	0	0	0	1
	Suicide	8	5	4	0	0	0	18*
	Total	51	29	32	11	3	2	129

*One report missing race information

APPENDIX C.3 Reviewed Child Fatalities with Abuse Findings

		White		Black		Other		
Infant (Age < 1)	Cause of Death	Male	Female	Male	Female	Male	Female	Total
	Drowning	0	1	0	0	0	0	1
	Homicide	3	2	3	1	1	1	11
	Medical Causes	1	0	3	1	0	0	5
	Vehicle Crashes	1	0	1	0	0	0	2
	SIDS	3	3	6	4	0	0	16
	Suffocation	4	1	1	1	0	0	7
	Total	12	7	14	7	1	1	42

				White		Black		Other
Ages 1 to 4	Cause of Death	Male	Female	Male	Female	Male	Female	Total
	Drowning	1	1	0	0	0	0	2
	Fire / Burn	0	0	1	2	0	0	3
	Firearm	0	0	0	1	0	0	1
	Homicide	3	4	1	2	0	1	11
	Medical Causes	0	0	1	2	0	0	3
	Other	0	0	1	1	0	0	2
	Poisoning	1	0	0	0	0	0	1
	Suffocation	1	0	0	0	0	0	1
	Unknown	0	0	1	0	0	0	1
	Total	6	5	5	8	0	1	25

		White		Black		Other		
Ages 5 to 14	Cause of Death	Male	Female	Male	Female	Male	Female	Total
	Drowning	1	0	3	0	0	1	5
	Fire / Burn	0	0	1	0	0	0	1
	Homicide	4	1	0	1	0	0	6
	Vehicle Crashes	1	1	2	2	0	0	6
	Total	6	2	6	3	0	1	18

		White		Black		Other		
Ages 15 to 17	Cause of Death	Male	Female	Male	Female	Male	Female	Total
	Fire / Burn	0	0	1	0	0	0	1
	Homicide	0	0	2	0	0	0	2
	Medical Causes	0	1	0	0	0	0	1
	Vehicle Crashes	0	1	0	0	0	0	1
	Suicide	1	1	0	0	0	0	2
	Total	1	3	3	0	0	0	7

APPENDIX C.4 Prevention Potential of Reviewed Child Fatalities by Abuse Classification

Confirmed Abuse

Cause of Death	Prevention Finding				
	Missing	None	Possible	Definite	Total
Medical	0	1	2	0	3
SIDS	0	0	2	1	3
Homicide	1	3	6	18	28
Suicide	0	0	0	0	0
Vehicle Crashes	0	0	1	4	5
All Other Acc.	0	0	3	7	10
Total	1	4	14	30	49

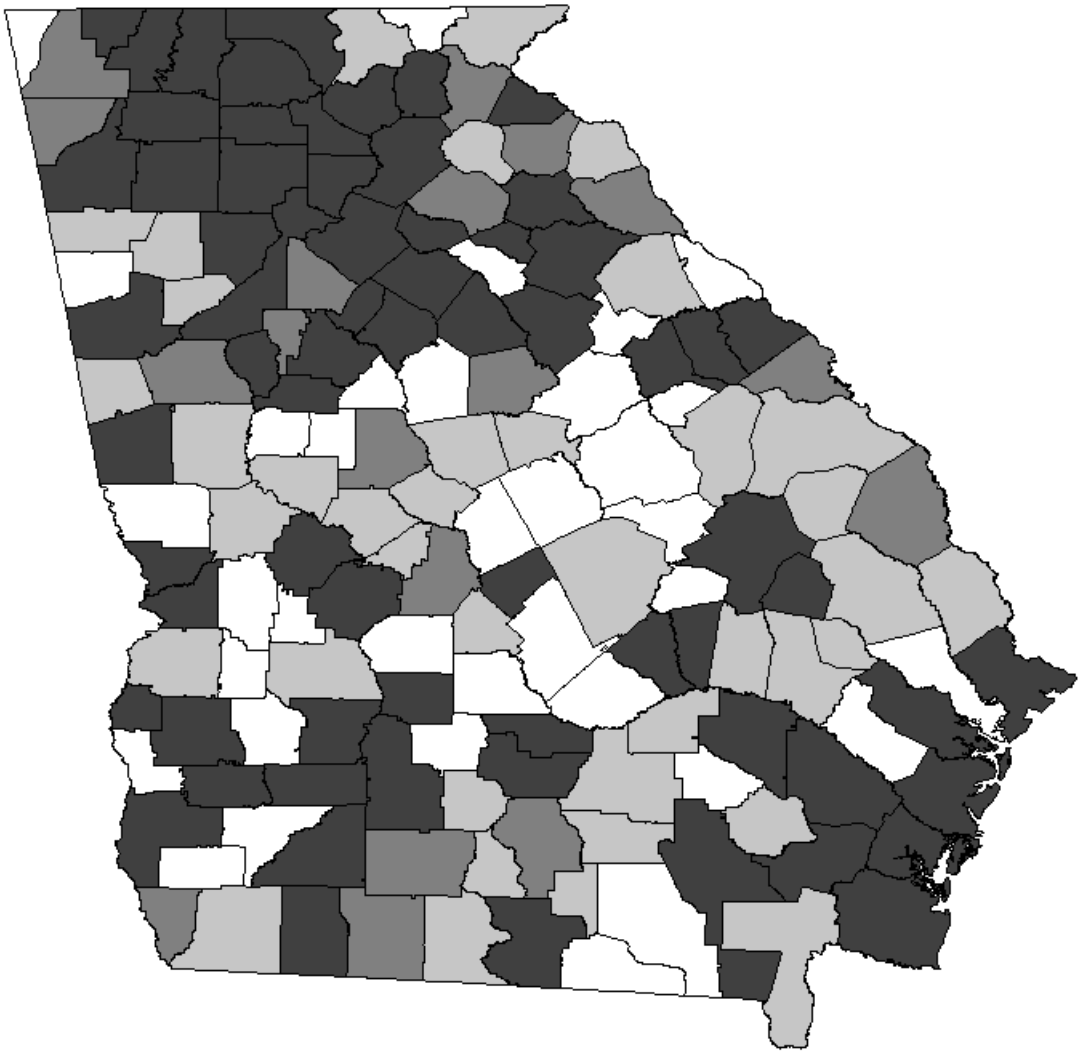
Suspected (but not confirmed) Abuse

Cause of Death	Prevention Finding				
	Missing	None	Possible	Definite	Total
Medical	0	0	6	0	6
SIDS	0	0	12	1	13
Homicide	0	0	1	1	2
Suicide	0	0	2	0	2
Vehicle Crashes	0	0	1	3	4
All Other Acc.	0	2	5	9	16
Total	0	2	27	14	43

No Reported Abuse

Cause of Death	Prevention Finding				
	Missing	None	Possible	Definite	Total
Medical	0	42	23	4	69
SIDS	4	33	38	0	75
Homicide	1	3	8	16	28
Suicide	1	5	9	5	20
Vehicle Crashes	4	14	43	61	122
All Other Acc.	3	13	33	29	78
Total	13	110	154	115	392

APPENDIX D
COUNTY COMPLIANCE WITH REVIEWING ELIGIBLE DEATHS



APPENDIX E
2000 CHILD FATALITY REVIEWS, BY COUNTY, BY AGE GROUPS

Appendix E presents county level data for the Child Fatality Review process in 2000. The data is presented for four age groups (infants less than 1 year old, children from 1 to 4 years of age, children 5 through 14, and teenagers ages 15 through 17). Four numbers are provided for each age group:

Total Deaths: The total number of deaths (all causes) for that age group. This number is based on Georgia death certificate data and only includes deaths to Georgia residents under the age of 18. This does include deaths of Georgia residents that occurred in other states and were reported back to Georgia, but it does not include deaths of out-of-state residents that occurred in Georgia.

Eligible Deaths: The number of SIDS, accidental, or violence-related deaths (eligible deaths) according to the death certificate classifications. Although other deaths due to medical or natural causes may be eligible for review according to OCGA 19-15-3(e), SIDS deaths are explicitly required to be reviewed, and accidental/violence related deaths should be reviewed as "sudden or unexpected deaths." Thus, this number represents a minimum number of deaths that should be reviewed. This is a subset of total deaths (DTH).

Eligible Deaths Reviewed: The number of SIDS, unintentional, or violence related deaths that were reviewed. This number is a measure of how well a county identified and reviewed the minimum number of appropriate deaths. This is a subset of the total "eligible" deaths.

Total Deaths Reviewed: This is the total number of child deaths in 2000 for which a Child Fatality Review Report was submitted. It includes deaths due to medical causes (other than SIDS) in addition to those deaths which were identified as eligible for review. This is based on the county of residence identified from the death certificate.

Appendix E
Child Fatality Reviews, by Death Certificate County of Residence

County	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
AGE	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Appling	2	2	2		6	1	2	1		4	1	2	1		4	1	2	1		4
Atkinson	3			1	4	2			1	3										
Bacon	1	1			2															
Baker	1				1															
Baldwin	5	1	4		10	1	1	1		3										
Banks	2				2	1				1										
Barrow	5		2	2	9			2	1	3			1	1	2			1	1	2
Bartow	11	3	3	1	18	3		2	1	6	3		2	1	6	3		2	1	6
Ben Hill	5		1	1	7	2		1		3	2		1		3	2		1	1	4
Berrien				3	3				2	2				1	1				1	1
Bibb	31	5	1	4	41	4	2		4	10										
Bleckley	3				3	1				1	1				1	1				1
Brantley	1		1		2			1		1			1		1			1		1
Brooks	1			1	2				1	1										
Bryan	3		1		4															
Bulloch	9	1	1	2	13	3	1		2	6										
Burke	3	2			5		1			1										
Butts	3				3															
Calhoun	1		1		2			1		1			1		1			1		1
Camden	7		1	1	9	2		1		3	2		1		3	2		1	1	4
Candler	4	1			5		1			1		1			1	1	1			2
Carroll	12	1	3	2	18	1		2	2	5	1		1	2	4	2		2	2	6
Catoosa	3	3			6	1	1			2	1	1			2	1	2			3
Charlton	1			2	3				2	2										
Chatham	26	5	3	8	42	6	2	1	7	16	6	2	1	3	12	6	3	1	3	13
Chattahoochee	1	1		1	3				1	1				1	1	1			1	2
Chattooga	3			2	5	2			2	4	1				1	1		1		2
Cherokee	19	5	2	8	34	1	4		8	13	1	3		8	12	1	3	1	8	13
Clarke	11		2	1	14			2	1	3			1	1	2	2		1	1	4
Clay	1				1															
Clayton	41	7	5	1	54	8	2	2		12	1				1	2		1		3
Clinch	2	1			3											1	1			2
Cobb	60	12	16	14	102	12	3	7	11	33	11	3	7	11	32	14	8	9	13	44

Appendix E
Child Fatality Reviews, by Death Certificate County of Residence

County	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
AGE	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Coffee		9	1	2	1	13		1	1		1	3								
Colquitt		9		3		12		1		3		4			2			2			3		3
Columbia		10	2	2	1	15		1	1	1	1	4		1	1	1	1	4		1	1	1	1	4
Cook		2		2		4		1		1		2												
Coweta		13	2	3	1	19		2	1	1	1	5		1	1	1		3		1	1	1		3
Crawford		1	2	1		4			1	1		2												
Crisp		7				7		3				3		2				2		4				4
Dade																								
Dawson		1		1		2		1				1		1				1		1				1
Decatur		5			3	8		1			2	3												
DeKalb		102	15	20	16	153		11	6	11	12	40		7	6	5	5	23		10	8	5	7	30
Dodge		3				3																		
Dooly			1			1																		
Dougherty		23	1	1		25		2	1	1		4		2	1	1		4		2	1	1		4
Douglas		4		2	2	8				2		2												
Early		1		1		2				1		1				1		1				1		1
Echols																								
Effingham		6		2	1	9				1	1	2												
Elbert				2	2	4					2	2					1	1				1	1	2
Emanuel		6		1		7		1				1		1				1		1				1
Evans		3	1	1	1	6					1	1												
Fannin		4	1			5		3	1			4		2	1			3		2	1			3
Fayette		6		1	2	9				1		1				1		1		1		1	2	4
Floyd		11		3	2	16		3		1	2	6		2		1	1	4		3		2	1	6
Forsyth		14	2	2	5	23		1		1	5	7		1		1	5	7		1		1	5	7
Franklin		1	1	1	1	4			1		1	2			1			1		1	1	1		3
Fulton		113	15	11	28	167		16	5	5	19	45		16	3	5	17	41		19	10	9	22	60
Gilmer		5				5		1				1		1				1		1				1
Glascock																								
Glynn		6	2	2		10				2		2				2		2		2		2		4
Gordon		8	1	3	1	13		1		1	1	3		1		1	1	3		1	1	1	1	4
Grady		4	1	1	2	8		3		1	2	6		3		1	2	6		3	1	1	2	7
Greene		3				3		1				1		1				1		1				1

Appendix E
Child Fatality Reviews, by Death Certificate County of Residence

County	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
AGE	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Gwinnett	58	10	21	21	110		10	5	14	14	43		10	5	13	12	40		13	5	15	13	46
Habersham	5		2	1	8		1		2	1	4		1		1		2		2		1		3
Hall	16	3	3	3	25		1	2	1	2	6		1	2	1	2	6		2	2	1	2	7
Hancock	3				3																		
Haralson	2				2																		
Harris	2		2		4																		
Hart			2		2				1		1												
Heard	2		1	1	4				1		1												
Henry	17	1	3	3	24		1	1	2	2	6			1	2	2	5			1	2	2	5
Houston	14	1	3	4	22		2		1	4	7		2		1	1	4		3		1	1	5
Irwin	3				3		1				1		1				1		1				1
Jackson	3	2	1	1	7		1	2	1	1	5			2	1		3			2	1		3
Jasper	2				2																		
Jeff Davis	7			1	8		2			1	3												
Jefferson	4				4		1				1												
Jenkins	1			2	3		1			2	3												
Johnson																							
Jones		1	2		3			1	1		2												
Lamar	1		1		2																		
Lanier	1				1		1				1												
Laurens	5	2	1		8			2	1		3												
Lee	1	1	1	4	7			1	1	4	6				1	4	5				1	4	5
Liberty	21	1	4	1	27		2		2		4		2		2		4		2		2		4
Lincoln	2				2																		
Long	1	1			2																		
Lowndes	17		1	1	19		2		1		3		2		1		3		3		1	1	5
Lumpkin	1	1	1		3			1	1		2			1	1		2			1	1		2
Macon	4	1	2		7		2	1	1		4		2	1	1		4		2	1	1		4
Madison	2				2		1				1		1				1		1				1
Marion	1				1																		
McDuffie	5	1		2	8		4			1	5		4			1	5		5	1		1	7
McIntosh	3		1	2	6					2	2					2	2					2	2
Meriwether	4	2	1		7		1	2	1		4												

Appendix E
Child Fatality Reviews, by Death Certificate County of Residence

County	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
AGE	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Miller																				
Mitchell	6		2	2	10	3		2	2	7	3		2	2	7	3		2	2	7
Monroe	3	2			5	1	2			3		1			1		1			1
Montgomery	1			2	3				2	2				2	2				2	2
Morgan	3	1	1		5		1	1		2		1	1		2		1	1		2
Murray	2	2	2	2	8		1	2	2	5		1	2	2	5	1	2	3	2	8
Muscogee	49	2	4	6	61	8	2	4	4	18	8	1	3	4	16	10	1	3	4	18
Newton	6	5	2	2	15	3	3	2	2	10	3	3	2	2	10	3	3	2	2	10
Oconee	3	1	1		5															
Oglethorpe				1	1				1	1				1	1				1	1
Paulding	8	1	3	1	13	2	1	1	1	5										
Peach	3	1	1	1	6	1		1	1	3										
Pickens	3	1	1	4	9		1	1	4	6		1	1	3	5		1	1	3	5
Pierce	2	1		1	4	1	1		1	3										
Pike	1				1															
Polk	7	1	2		10	1		2		3										
Pulaski	1	2	1		4		2	1		3										
Putnam	1		2		3	1		2		3	1				1	1				1
Quitman	1		1		2			1		1			1		1	1		1		2
Rabun	1		1		2			1		1										
Randolph	1		1		2			1		1			1		1			1		1
Richmond	42	6	8	5	61	5	2	3	4	14				1	1				1	1
Rockdale	3	1	4	2	10	1	1	2	2	6		1	1	2	4		1	2	2	5
Schley																				
Screven	5	2	1		8	1		1		2			1		1			1		1
Seminole	2			1	3	1			1	2				1	1				1	1
Spalding	9		1		10			1		1			1		1			1		1
Stephens	4		1	3	8	1		1	2	4	1		1	2	4	1		1	2	4
Stewart				1	1				1	1										
Sumter	4			1	5	1				1						1				1
Talbot	2	2			4		2			2										
Taliaferro																				
Tattnall	2			5	7				3	3										

Appendix E
Child Fatality Reviews, by Death Certificate County of Residence

County	Total Deaths					"Reviewable" Deaths					"Reviewable" Deaths Reviewed					Total Deaths Reviewed				
AGE	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Taylor		1		1	2			1		1			1		1			1		1
Telfair		1			1															
Terrell		1		1	2												2			2
Thomas		2	1	3	1	7		1	1	3	1	6		1	1	1	3		1	1	1	3
Tift		9	2	1	1	13			1		1	2								
Toombs		2			2	4					2	2								
Towns		1				1														
Treutlen		1	1			2														
Troup		13		3	2	18		2		2	1	5		2		2	1	5		4		2	1	7
Turner		2	1		1	4														
Twiggs		1	1	1		3														
Union		2		1	1	4					1	1								
Upson		2	1	3		6				2		2								
Walker		8	2	3	1	14		2	1		1	4		1	1		2		2	1	1		4
Walton		5	3	3		11		2	2	1		5		2	2		4		3	2			5
Ware		4			1	5					1	1				1	1			1		2	3
Warren		3			1	4					1	1				1	1					1	1
Washington		2				2														
Wayne		2		1		3		1				1		1			1			1		1		2
Webster																				
Wheeler					1	1					1	1				1	1					1	1
White		3		1		4		1				1		1			1			1			1
Whitfield		9	1	3	1	14		2	1	3		6		2	1	3		6		4	1	4		9
Wilcox		3				3														
Wilkes		1	1	1		3				1		1								
Wilkinson		2	1			3														
Worth		1	1	1	1	4		1		1		2		1		1		2		1		1		2
Georgia		1125	174	237	225	1761		182	81	135	174	572		125	52	91	113	381		167	76	112	129	484

APPENDIX F
DEFINITIONS OF TERMS AND ABBREVIATIONS USED IN THIS REPORT

A-A
African-American

Child Abuse Protocol Committee
County level representatives from the office of the sheriff, county department of family and children services, office of the district attorney, juvenile court, magistrate court, county board of education, office of the chief of police, office of the chief of police of the largest municipality in county, and office of the coroner or medical examiner. The committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.

Child Fatality Review Report
A standardized form required for collecting data on child fatalities meeting the criteria for review by child fatality review committees.

Child Fatality Review Committee
County level representatives from the office of the coroner or medical examiner, county department of family and children services, public health department, juvenile court, office of the district attorney, law enforcement, and mental health.

Eligible Death
Death meeting the criteria for review including death resulting from SIDS, unintentional injuries, intentional injuries, medical conditions when unattended by a physician, or any manner that is suspicious or unusual.

Form 1
A standardized form required for collecting data on all child fatalities by corners or medical examiners.

Injury
Refers to any force whether it be physical, chemical (poisoning), thermal (fire), or electrical that resulted in death.

Intentional
Refers to the act that resulted in death being one that was deliberate, willful, or planned.

Medical Cause
Refers to death resulting from a natural cause other than SIDS.

Natural Cause
Refers to death resulting from an inherent, existing condition. Natural causes include congenital anomalies, diseases of the nervous system, diseases of the respiratory system, other medical causes and SIDS.

"Other" Race
Refers to those of Asian, Pacific Islander, or Native American origin.

"Other" as Category of Death
Includes deaths from suffocation, choking, poisoning, and falls (unless otherwise indicated).

Perpetrator
Person(s) who committed an act that resulted in the death of a child.

Preventable Death
One in which with retrospective analysis it is determined that a reasonable intervention could have prevented the death. Interventions include medical, educational, social, legal, technological, or psychological.

Reviewed Death
Death which has been reviewed by a local child fatality review committee and a completed Child Fatality Review Report has been submitted to the Georgia Child Fatality Review Panel.

Risk Factor
Refers to persons, things, events, etc. that put an individual at an increased likelihood of dying.

Georgia Child Fatality Review Panel
An appointed body of 16 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data.

Sudden Infant Death Syndrome (SIDS)
Sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. In this report, SIDS is not considered a "medical" cause.

Trend
Refers to changes occurring in the number and distribution of child deaths. In this report, the actual number of deaths for each cause is relatively small for the purpose of statistical analysis, which causes some uncertainty in estimating the risk of death. Therefore, caution is advised in making conclusions based on these year-to-year changes which may only reflect statistical fluctuations.

Unintentional Death
Refers to the act that resulted in death being one that was not deliberate, willful, or planned.